MENTAL HYGIENE

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THE MEDICAL SURVEY PROGRAM

THE Medical Survey Program of Selective Service, described in Medical Circular No. 4, has now completed its first six months of operation, and some estimate of its practicability is in order. The securing of medical histories of draft registrants for armed-forces induction stations, which in brief is the objective of the medical survey, had proved its value beyond question in such states as Connecticut, New York, New Jersey, and Massachusetts prior to its official adoption. A number of other states, through the assistance of Dr. Luther E. Woodward, Field Consultant of The National Committee for Mental Hygiene, had already voluntarily established a medical-survey program. In those states the program had the advantage of the backing, imagination, and energy of persons who were actuated by the pioneering spirit, who knew the program to be in line with good medical practice, and who, therefore, wanted an effective method of carrying out its provisions. The present record shows that there were in addition many other states who were waiting for official sanction before launching such a program, who likewise wanted it to work, but who needed authoritative support and the formulation of procedures.

Of course experience under a wide variety of conditions has shown ways of improving here and there the operation of the survey, but the fundamentals of securing records from state files, local agencies, and schools has stood the test, whenever those in authority have made a conscientious effort to put it into operation. To implement this program further, funds are needed to pay costs that cannot be met on a volunteer basis. Names must be cleared through confidential

exchanges, and in some states there is need for reimbursing the personnel of public assistance programs because state legislatures have not met to provide for the time spent on the medical survey. Steps have been taken to meet these costs, which in every sense are fully justified.

The confidence that Selective Service has placed in the willingness of social workers and public-health nurses to give freely of their time and effort has been fully vindicated, as has been its confidence in the generosity of the local Selective Service boards. Over seven thousand volunteer medical field agents are at present serving on this program. As a result of the program, a number of states have for the first time organized central files of state-institution patients in a way that will assure benefits of a permanent nature.

This effort to foresee the danger signals of mental unsuitability for military service is the most concrete and widespread mental-hygiene undertaking ever instituted, considering the cost and the speed with which it was put into operation.

CLIFFORD WHITTINGHAM BEERS *

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THE man whose name and whose work we honor to-night had a career of extraordinary dramatic contrasts; and his passage from the depths of despair to the heights of triumph was spanned by the short space of three decades.

In the year 1900, Clifford Beers, as a young man three years out of college, broke down emotionally, attempted to commit suicide, and was admitted to an institution for the insane in a state of almost complete mental confusion, with acute delusions of persecution. As the doors of the hospital closed on him, his friends and relatives could scarcely have doubted that this young life had ended in tragedy, complete and irrevocable.

In 1930, Clifford Beers, in his fifties, stood on a platform in Washington as the prime instigator and the central figure of the First International Congress on Mental Hygiene. Fifty nations were represented. In thirty of these nations—from Finland to the Argentine, from Turkey to New Zealand—national committees on mental hygiene were in operation—all as a result of his achievements. Throughout the world, he was recognized as the founder of one of the great social movements of modern times.

The tale of this progress from overwhelming defeat to the summit of great achievement is a fascinating chapter in the history of the human spirit.

Even in his college days at Yale, Beers was handicapped by serious emotional problems. The illness of an elder brother, stricken with what was supposed to be epilepsy, developed in Clifford an obsession that he himself would be affected with the same disease. He dared not rise to make a recitation for fear an attack would come on at that moment.

* Presented at a symposium on Clifford Beers and the future of the mental-hygiene movement held at Cooper Union Forum, New York City, January 4, 1944, as one of the Forum's series, "Rough Sketches of the Future."

Weeks would pass without any other record than a zero or a blank opposite his name. By sheer will power, however, and through the forbearance of his teachers, he obtained his degree in 1897.

In spite of the strain that these college struggles had entailed, he began clerical work six days after graduation in the Tax Collector's Office of the City of New Haven. A year later he obtained a similar post in New York, and in 1899 joined the staff of a life-insurance company in the heart of the Wall Street district. Grave emotional strain persisted, and in June, 1900, he reached a point where, in his own words, "my will had to capitulate to Unreason." He gave up his work, returned to New Haven, and—now convinced that he was a confirmed epileptic—became worse and worse. Eight days after leaving New York, he attempted suicide by jumping from his bedroom window on the fourth floor of his home.

The physical injuries were serious, but not irremediable; but irrational fear developed into grave and deep-seated delusions. Beers believed himself to be branded as a criminal for attempted self-murder and in imminent danger of legal punishment. He thought that the college cheers in the street—on the occasion of what should have been his triennial reunion—were denunciations for the disgrace he had brought on his alma mater. He heard voices and he saw phantoms. He became convinced that the members of his family were imposters, police officers masquerading to deceive him. The clinking of the ice in a water pitcher was some sort of device of the malign detectives who surrounded him.

After eight months in one private sanatorium, Beers was committed to a second institution in 1901. Here conditions were somewhat better and his state began to improve; but he still believed that the devoted brother who came to visit him was a detective in disguise; and suicide was still constantly in his mind. In August, 1902, he got a friend in whom he had some confidence to check on his brother's New Haven address and wrote to that address a letter to be brought as a passport. On the day that his brother handed him this letter, taking it from an old leather pocketbook that Clifford recognized as his own, the light broke, and the painful delusions of the past two years vanished like a dream.

Beers says of this episode, "No man can be born again, but I believe I came as near it as ever a man did."

After this, the patient was much happier, but by no means cured. He had merely passed from the depressed to the manic stage of his disease. He was now full of hopes and dreams, as rosy as his fears had been lurid. He wrote letters twenty or thirty feet long on large sheets of manila paper. He began to investigate the hospital and to attempt to reform it; and these activities were visited with severity and repression and downright cruelty common in those days of unintelligent care of the insane. Physical violence and physical restraint followed, including fifteen hours in a strait-jacket.

Then followed transfer to a third hospital, this time a state institution. Again, after a good start, Beers's efforts at reform led to fourteen weeks of confinement in the violent ward. As his sense of proportion gradually reasserted itself, he began to pursue more subtle policies. He finally smuggled out a letter of protest to the governor of the state, a 32-page booklet of revelations as to the horrors of the three institutions in which he had been illtreated. Strange to say, the letter was delivered and read and actually led to temporary mitigation of the practices denounced. Encouraged by this slight success, Beers determined that in order to secure real reform, he must regain his liberty; and after some months of good behavior, by the fall of 1903 he was discharged.

This was, however, only one milestone on a long road. Beers obtained a position with his old firm in New York. The zeal for reform in the treatment of the insane was, however, still with him and in urgent form. He opened his grandiose plans to President Hadley of Yale. He planned to appeal to President Theodore Roosevelt and a prominent and very wealthy New York citizen. These apparently fantastic dreams frightened his friends, and to forestall dangers of a relapse, he agreed to accept a temporary voluntary commitment to one of the private sanatoria where he had previously been incarcerated. He held himself in such control, however, that after a single month he was once more sent out into the world.

In the summer of 1905, there happened the most extraordinary event in this series of miracles. Being at Stockbridge,

Massachusetts, Beers wrote—as a complete stranger—to the Hon. Joseph H. Choate, who had his summer residence there, and asked for an interview. The letter was a clever and appealing one and the interview was granted. Mr. Choate thought the project of a national movement to improve the conditions of the care of the insane a "commendable one." "If you will submit your ideas in writing," he said, "I shall be glad to read your manuscript and assist you in any way I can. To consider fully your scheme would require several hours, and busy men cannot very well give you so much time. What they can do is to read your manuscript during their leisure moments." Is it too much to imagine that Mr. Choate may have said to his family at luncheon, "An interesting young man came to see me this morning—just out of an insane asylum and burning to start a crusade for better care of people like himself. It needs doing, and I asked him to put it into writing. But I don't suppose I shall hear from him again."

Yet if Mr. Choate thought anything like this, he was wrong; for here was the real turning point.

One week later Beers began his book, *A Mind That Found Itself*.

This book—from which essentially all that I am saying to you to-night is derived—proved to be one of the most remarkable personal documents in history. In it, Beers described completely and frankly and vividly all that he had experienced. Its exposure of the stupid and brutal methods employed by some of his doctors and attendants was of importance; but even more significant was the revelation of his own feelings, of his own emotional reactions, in every phase of depression and delusion, of manic enthusiasm and exultation. Gradually, step by step, one sees this enthusiasm tempered by ascendant reason, so that the grandiose screeds on manila paper began to cohere into a practical program of reform. No abstract program by itself could have been effective; but this compelling picture of a mind finding itself, seen from inside, carried an overwhelming weight of conviction. Here was the experimental proof that mental disease of a grave type could be cured. Here was the most appealing argument for a system of treatment that would promote such recovery of the faculties.

Beers sent a copy of his preliminary manuscript not only to Choate, but also to William James at Harvard. Within a fortnight (July, 1906) Professor James wrote to Beers as follows:

> "Having at last 'got round' to your MS, I have read it with very great interest and admiration for both its style and its temper. I hope you will finish it and publish it. It is the best written out 'case' that I have seen; and you no doubt have put your finger on the weak spots of our treatment of the insane, and suggested the right line of remedy. I have long thought that if I were a millionaire, with money to leave for public purposes, I should endow 'Insanity' exclusively."

This letter came to Clifford Beers "as a rescuing sun, after a period of groping about for an authoritative opinion that should put scoffers to flight."

The manuscript—and, later, the book itself—won similar support from a distinguished company. Professor Wilbur L. Cross (Beers's English teacher at Yale, and later Governor of Connecticut), President Jacob Gould Schurman of Cornell, Jane Addams, Julia C. Lathrop, Dr. Henry van Dyke, Anson Phelps Stokes of Yale, and—above all—Dr. Adolf Meyer (later Director of the Phipps Psychiatric Institute at Johns Hopkins) were among the number; and it was Dr. Meyer who suggested the name "Mental Hygiene" for the new field of human endeavor to be inaugurated.

A Mind That Found Itself was originally published in March, 1908, three years after the interview with Mr. Choate at Stockbridge. By this time Beers had the approval of many of the most eminent leaders of American thought for the creation of a National Committee for Mental Hygiene. It was thought wiser, however, to begin first, as an experiment, on a smaller scale. So, on May 6, 1908, thirteen men and women met in Anson Phelps Stokes's home in New Haven and formally organized the Connecticut Society for Mental Hygiene—the first organization in the world to be created "to work for the conservation of mental health; to help prevent nervous and mental disorders and mental defect; to help raise the standards of care for those suffering from any of these disorders or defects; to secure and disseminate reliable information on these subjects; to coöperate with federal, state, and local agencies or officials and with public and private agencies whose work is in any way related to that of a society for mental hygiene."

For the first five years after Clifford Beers's acute breakdown in 1900, he stood almost alone except for a handful of sympathetic, but not too optimistic relatives and friends. For the next five years after his interview with Joseph Choate, support from the greatest personalities in the land grew like a snowball. In 1908 and 1909 Jacob A. Riis, Dr. W. H. Welch of Johns Hopkins, Mr. Henry Phipps, and Cardinal Gibbons of Baltimore came into the picture. William James contributed $1,000; Mr. Phipps gave $50,000 for the work of the Committee and sent $5,000 to Beers personally, which enabled him to pay off the costs of publication of the book. On February 19, 1909, The National Committee for Mental Hygiene was formally organized.

Dr. George S. Stevenson will carry on from here and tell you about the progress of the world movement thus initiated from 1909 to 1939. It was, however, the germinal years from 1905 to 1909 that determined its success; and the central fact of those significant years was the book. Harriet Beecher Stowe's *Uncle Tom's Cabin* had a great influence upon the anti-slavery movement; but it was one of many impulses toward the same end. *A Mind That Found Itself* was unique in creating a new social force which might not have arisen for many years without its stimulus.

The content of this book was peculiarly significant in relation to its objective. Its aim was to bring realization of the fact that mental disease was a sickness like other sicknesses, "a symptom, not a sin"; that it was, like other sicknesses, in large measure curable and preventable. For generations, hundreds of thousands of the insane had raged at their brutal treatment, had dreamed of turning the tables on their inhuman guardians. Here, one of them passed through the gates of spiritual death and came back to tell the tale. He proved his point in his own triumphant experience. He demonstrated that in resenting strait-jackets and physical punishment, he had been sane, and that, in using such methods, his keepers had been insane—if to be sane is to act reasonably and in accordance with facts. As Jacob Riis wrote to Beers in 1908, "In losing your reason you found, I hope, ours for us in this pitiful matter."

And, finally, this book is a source of wider inspiration, in its demonstration of the power and the glory of the human

will. The long, lonely struggle for sanity, the day-by-day growth of balance and restraint, by which Clifford Beers welded his inchoate dream into a practical program is a noble thing. He harnessed the dynamic drive of his nature—which was essential to his phenomenal success—so that it became an effective force. It was not a triumph of reason over emotion, which, if complete, would be deadening. It was a triumph of reason and emotion fused together, through infinite suffering, through unflinching courage, through undying faith.

Perhaps we may all learn something from the spirit as well as from the immediate message of Clifford Beers. We live to-day in a world where whole nations suffer from delusions as fantastic as any of his—and far more menacing. For us, who fight against these nations and these phantasies, the hope of rebuilding a sane and friendly world may seem as dim as the prospect of refashioning man's attitude toward mental disease must often have appeared to Clifford Beers. Perhaps if we can cultivate the unconquerable power of his spirit, we can win our triumph as he accomplished his.

MENTAL-HYGIENE FIRST AID FOR PRECOMBAT CASUALTIES *

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FIRST aid, in its generally accepted medical sense and as used in army practice, has come to mean an immediate, temporary measure to care for a casualty until the arrival of a medical-corps officer. Such temporary help can be administered by personnel who have not had the training of the physician or the medical specialist. When such personnel are given suitable understanding and specific suggestions for preliminary, temporary help, they can be of increased aid to the medical officer. Quick recognition of the injury, knowledge as to how and where to apply a tourniquet to stop bleeding, or when to administer sulfa pills, has been responsible for the saving of life many times in this war.

The present paper was prepared as a first-aid pamphlet to assist officer personnel in the early recognition of mental problems and disturbances of normal behavior, with a view toward proper disposition of this type of casualty. The officer in charge of troops seldom has time to deliberate about treatment of the soldier who is "nervous," who acts "queerly," or who is always "getting out of line." Practice in the application of first-aid measures in order to decrease or to eliminate such unnecessary burdens upon the line officer has proved to be an efficient method for improving the effective functioning of his unit.

A Lesson from Two Wars.—The army has learned much about dealing with mental casualties since World War I. At

* NOTE TO CHAPLAINS: As supplementary to this article, see the two pamphlets, *The Ministry of Listening* and *The Ministry of Counseling*, issued by the Federal Council of the Churches of Christ in America, 297 Fourth Avenue, New York 10, N. Y.

that time, almost any soldier who was incapacitated in action without evidence of a specific physical basis was labeled a case of "shell shock." The profession of psychiatry has made tremendous strides since then in the understanding and treatment of this problem. It has been able to apply its knowledge to the weeding out, prevention, care, and treatment of the so-called mental or psychiatric casualty. This has been the function of the military psychiatrist.

The medical officer and the military psychiatrist within the armed forces is seldom in direct touch with troops unless individuals already suffering from a breakdown are brought to him. The army realizes that it must depend primarily upon its commissioned officers to help in solving this problem. Neither the army nor the line officer wants a repetition of a record such as that of the thirty-three months from April 1, 1917, to December 31, 1919, when 97,650 men, neuropsychiatric disorders, were admitted to military hospitals. It has cost the United States an average of $30,000 to care for a service neuropsychiatric disability from inception to cure or death. To-day, with the tremendous increase over the last war in the number of our forces, as well as in the specialized requirements of all classes of duty, this problem must be given even more serious consideration. It is not expected that an officer take time and energy away from his group responsibilities to continue to deal with those soldiers who have failed to benefit from his efforts to help them come into line with his platoon, company, or unit. *It is in what he can do, as well as in his early recognition of the more complicated problems, that the army is interested.* It realizes that, especially in the realm of emotional and behavior disorders, there is much for which the officer cannot be responsible. But the greater his understanding of what lies within the soldiers' minds and the purpose of their behavior, the more efficient can be his handling of troops and the more clearly can he realize why certain types of mental problem require the skills of the military psychiatrist.

The line officer is fully aware of his responsibilities as a leader of his unit. This responsibility, however, will apply, in the main, to those soldiers who are physically and mentally capable of performing normally their assigned duties.

When special problems arise in the functioning of any of his men, the officer is expected to utilize the many additional resources provided by the army. These special problems are the theme of this paper. We shall discuss them as they are likely to appear in the daily round of activities, as obstacles to the normal flow of the military activity of a unit. They will be the "danger signals." But let us first consider the general problem of our civilian army as a frequent cause of these personal problems of military adjustment.

From Civilian to Soldier.—The United States Army to-day is largely a civilian army. This process of becoming a soldier, of subordinating one's self to army needs, requires a great deal of readjustment. In our democracy, a man lives a life filled with individual choices, decisions, likes and dislikes. In his community—perhaps to a few or perhaps to many—he has become known as a distinct personality, with opinions and habits of living, and allowances are made for his peculiarities. Some recognize and accept his shortcomings and others do not. He is frequently able to get some one to help him with his everyday problems. In this manner, a man may live in an environment in which he has been able to carve out a place that is more or less satisfying to himself. When this process has taken place for from eighteen to thirty-eight years, habits, attitudes, and ways of life have become relatively set.

The strain of induction and transition from civilian life to that of a soldier is something that the majority of officers have experienced, although by now this experience may be far in the past, and they may smile with a military aloofness at the "small things" that concerned them then. But the officer, like any of the men with whom he is charged, is subjected to constant authority, and the necessity for decisions, alertness, and personal sacrifice is ever present. He may be moved at a moment's notice, with his men or even individually. He is expected to acclimate himself to change as a matter of course. The majority of his men have a similar environment to face, but some do not, and may never be able to, adjust to this mode of living. The reasons for this may be well beyond his control or influence. They will hinder

his work, but there are measures that he can take to deal with them.

Mental disease, behavior problems, and difficulties in learning are deficiencies or illnesses for which the individual soldier may not be responsible. A person of good or even superior intelligence is just as apt to have mental, emotional, or behavior difficulties as a person of limited intelligence. Every one will agree that people often act the way they feel rather than the way they think. We are not always reasonable. One often hears the question, "How could you do this when you know better?" The answer frequently is, "I felt like it," or, "I didn't think," or, "I didn't realize." Similarly, every one has had the experience of feeling badly upset or confused at times without knowing the reason why. It may be the "I just don't care" feeling.

The army has learned from experience that mental illness or breakdown may be a transient, a periodic, or a chronic illness, and, therefore, that a soldier with a personality weakness may appear perfectly acceptable at the brief induction screening. He may not break down or become "a headache" to his superiors until he experiences the increasing pressure and tensions inherent in army life at its various stages. Soldiers show their feelings and states of mind most frequently in their behavior. With this as a starting point, valuable clues can be gathered as to the state of mind or the normality of a soldier by observing him at work, at recreation, or at any other period.

It does not require a psychiatrist to recognize that there is something radically wrong with the soldier who is chronically late for formation, who is always without the necessary materials for instruction or training, who is persistently careless with his equipment or his person, or the man who stays by himself and is friendless, or the soldier who does not enter into activities other than those insisted upon, or the chronic worrier, or the "calamity guy." All of these types of soldier not only affect the morale and efficiency of the troops, but they may be exhibiting signs of an early mental disorder which may either respond to treatment or become progressively worse.

DANGER SIGNALS

The Importance of Early Detection.—It is a commonly accepted belief that the early recognition and treatment of soldiers with physical ailments are of the utmost importance in their speedy recovery and return to duty. Simple physical complications, if neglected, may soon become serious, if not totally disabling. In addition, certain physical conditions, when infectious, may affect a whole unit, causing great difficulties. That is why line officers, as well as enlisted men, are given careful training in the detection of "signs of physical ailments" and "first aid" and "self aid" for physical injuries.

There is a close parallel between first aid for physical casualties and first aid for "mental" casualties, also known as "emotional maladjustments" and "nervous conditions." Here, too, early detection is extremely important.

Some types of emotional condition are highly contagious, spreading rapidly to other members of the group or unit. Mass fear reactions are fairly common, as, for example, "panic," "mass hysteria," or "mass depression."

It would be safe to say that any problem that interferes with the normally to be expected adjustment of the soldier to his duties and their performance should immediately raise a question as to what this means. Unusual or abnormal behavior is always a "sign" or "danger signal" which deserves to be understood so that it may be used to detect those who are in danger of becoming a liability to themselves, to their associates, and to the army.

Types of Danger Signal.—There are many individual and varied shades of danger signal that deserve attention. It would be impossible to remember all of them. For some practical understanding of the larger patterns in which they may be found, however, they can be grouped into (1) physical difficulties, (2) intellectual difficulties, and (3) emotional difficulties. While there is much overlapping among these groups, they will be discussed here, for the sake of simplicity, as if they could be separated. In considering any danger signal at all, there are two very important elements to keep in mind. The first of these has to do with the frequency of occurrence of the danger signal and the second with its persistence over a period of time.

It is quite reasonable to expect that many of the danger signals listed below will be found to apply to perfectly normal persons at some periods in their lives. It does not help simply to label a soldier "a misfit," "a nut," "abnormal," "a psycho," or "maladjusted." Abnormal behavior is, after all, only a danger signal that should make the officer alert to the need for further careful observation of the soldier. It should serve as a *warning* against making "rash" decisions about him. The number and severity of the signs are frequently a kind of guidepost in deciding whether further action should be taken or what disposition should be made in a particular case.

As to the second point, it should be clear that, in general, the longer a symptom has been present, the more important it is as a danger signal. Another way of looking at this same point is to note whether a given danger signal persists despite discipline or reclassification or discussion with and guidance of the soldier. The symptom might be considered "chronic," just as purely physical symptoms that persist may be considered chronic.

It is important to remember that the line officer is not expected to be able to diagnose a "case" or to treat it. An adequate understanding of the fact that this is a job for the professionally competent authority will undoubtedly result in a more efficient handling and disposition of men.

Physical Signs of Maladjustment.—The appearance of a physical symptom is very often the first sign that a soldier is emotionally upset or even mentally ill. Naturally, any soldier may refer himself to the infirmary or be referred there by his commanding officer. Frequently, upon medical examination at the infirmary or hospital, no physical or organic basis is found for the physical symptom. This may be so because the emotional upset can express itself in a physical complaint of the body; that is the way the emotional tension is "translated" into a physical malady. This should not be considered surprising; we all recognize, for example, that worry may cause loss of appetite, a headache, fatigue, and even a feeling of weakness. Similarly, anxiety, worry, fear, tension, and other conditions of the kind may produce a wide variety of physical ills, some of which are listed here.

Because this is so, the condition is often referred to as a "psychosomatic complaint." These are very important "danger signals." The following are common physical complaints noted in the military service, which may have a "mental" cause behind them. The officer will recognize some of these as familiar, everyday signs of the "nervous" or unbalanced person. Commonly, a number of these symptoms occur together:

1. Pains or pressures in the head:
   a. Frequent headaches (especially if the soldier complains of vague, unbearable headaches which cannot be localized).
   b. Pressures or queer sensations in the head.
2. Disturbances of vision:
   a. Pains in the eyes.
   b. Mists or spots before the eyes, "blackouts," blurring of vision.
   c. Double vision (seeing double).
   d. Extreme sensitivity to light.
3. Disturbances in hearing:
   a. Extreme sensitivity to loud noises.
   b. Temporary loss or decrease in hearing.
4. Disorders of the digestive system:
   a. Unexplained loss of appetite; complaints of "gas" in stomach.
   b. Increase in fussiness about food.
   c. "Peculiar" eating habits; unusual table manners.
   d. Difficulty in swallowing, nausea, vomiting.
   e. Chronic constipation, diarrhea.
   f. Shifting pains in the abdomen.
5. Disorders of the respiratory system:
   a. Difficulty in breathing, "asthma," weakness.
   b. Unexplained pains in the chest (especially on the left side).
   c. Unusual sensations or pain in the heart, rapid heart, throbbing, palpitation.
6. Enuresis (uncontrolled bed wetting); increased frequency, day or night.
7. Shifting pains in the body, peculiar sensations, hot and cold flashes.
8. Difficulty with limbs:
   a. Sudden incoördination and awkwardness.
   b. Sensations of pains or frequent cramps in the arms or legs.
   c. Temporary or prolonged inability to use limbs.
9. Uncontrolled movements of the body:
   a. Trembling of hands and of body.
   b. Muscle spasm (especially of facial muscles).
   c. Convulsions.
   d. Jumpiness.
10. Excessive fatigue, weakness, lethargy.
11. Disturbances in sleeping habits:
   a. Insomnia or inability to sleep.
   b. Nightmares; excessive talking in sleep; sleep walking.

Intellectual Difficulties in Adjusting.—By intellectual difficulty in adjusting we mean the inability of a soldier to apply his mental powers to the extent of which he is capable. He may be unable to learn rapidly or he may be unable to retain what he has learned. He may show a deficiency in training for a particular army assignment or school, or for any army training at all. Of course, the line officer will not often meet a total mental dullard or feebleminded individual in the army, because he is usually discovered at the time of his induction into the army and rejected on the basis of mental tests. Nevertheless, some do slip in, and the problem of how to deal with them has to be considered. Moreover, many soldiers act as if they were mentally dull or inapt because they are illiterate or have had an inadequate educational background and, more particularly, because they suffer severe emotional difficulties. Our discussion here is centered on the disability in intellectual functioning, whatever the cause.

1. Inferior mental ability (mental level too low to meet minimum army requirements), unusual suggestibility, gullibility.
2. Inadequate mental ability for the assigned army job:
   a. Slow learning.
   b. Dullness in army school.
   c. Inability to pass regular tests in army school.
   d. Loss in ability to proceed with army school after initially making good progress.
3. Disturbances of memory:
   a. Inability to retain what has already been learned.
   b. Mental confusion—confused about where he is, the date, and so on.
   c. Loss of memory for certain areas of experience only.

"Signs" of Emotional Difficulties.—The term "emotional difficulty"—or, more commonly, "emotional maladjustment"—covers a very wide variety of conditions. By the time individuals have become adults, they have usually developed a self-responsible manner of behaving. All of us are "emotional," some more so than others. Some of us manage to "get by" in civilian life, despite an over-emotional or a "nervous" condition; others have brief periods of "nervous breakdown"; while still others suffer a severe or long-term "breakdown." The transition from civilian to army life presents mental hazards to the soldier; it is not

surprising, therefore, that some reveal "signs" of increased emotional stress. These "signs" may be the first evidence that a serious upset is impending, and it is important that they be found out as soon as possible by the line officer. The following are some of the more frequent of these "signs" noted in the military service:

1. "Aggressive" behavior (not antisocial):
   a. Excessive talkativeness.
   b. Attacks of unreasonable giggling.
   c. Period(s) of excitement.
   d. Always "griping" and "grousing," grumbling.
   e. Fault-finding; over-critical of others.
   f. Increase in cursing; increase in profanity.
2. Aggressive behavior (antisocial):
   a. Disrespectful to or resentful of army authority.
   b. Refusal to obey orders.
   c. Not amenable to simple discipline.
   d. Petty thievery (especially if chronic).
   e. Increased use of alcohol.
   f. Delinquency.
   g. Frequent fighting.
3. Unfavorable "mood":
   a. Stays by himself; lack of social relations with other soldiers.
   b. Does not put forth effort; lack of interest in work; lack of "drive."
   c. Seems unhappy, dejected, depressed.
   d. Crying spells.
   e. Shy, timid.
   f. Upset by criticism.
   g. Excessive "homesickness."
   h. Seems generally confused.
   i. Unusual calm in a soldier previously not showing this reaction.
   j. Unusual elation or excitement.
   k. Very anxious or fearful.
4. Over-emotional behavior:
   a. Irritability.
   b. Frequent loss of temper.
   c. Sudden changes of mood from one extreme to another.
   d. Inability to make decisions.
   e. "Nervous" and tense.
   f. Stuttering.
5. Peculiar behavior:
   a. Increase in lack of personal cleanliness; excessive cleanliness.
   b. Odd body movements; odd posture.
   c. Unusual manners while eating in mess hall; failure to attend mess.
   d. Difficulty with simple tasks (like making a bed, etc.).
   e. "Hears voices"; "sees ghosts"; talks to himself; absentminded; considered "goofy" by others, the butt of jokes; appears gullible, preoccupied.

6. Abnormal sexual behavior or feelings:
   a. Increase in masturbation, worry over it.
   b. Abnormal attachment to other soldiers.
   c. Complete loss of interest in opposite sex.
   d. Sex perversions.
   e. Impotence or worry over it.

SPECIAL PROBLEMS

In this section, several of the most frequent problems observed among soldiers will be discussed, in the light of our understanding of some basic causes. We shall come to understand how deep a problem may actually be, though it may appear as only a minor disturbance. These types of soldier will show us the importance of a full study by the psychiatrist for an adequate handling of the problem.

The AWOL.—A recent detailed study of the AWOL problem at an army post has revealed the important fact that of several hundred AWOL's studied carefully, 15 per cent were discharged because they were basically unsuitable for military service. The majority of these were discharged either by Section II or Section VIII, AR 615–360, the basic reason being not that they were AWOL, but that their offense had been caused by severe personality problems.

The most important factor concerning the AWOL is the absence of a sense of duty and responsibility to the service. There are many reasons why a soldier will go AWOL. First, we find soldiers who, for some reason, have not developed a mature personality, judgment, or the sense of duty necessary to understand the full meaning of army responsibility. This occurs particularly in young soldiers, frequently those who enlisted because of the desire for a thrill and new experience, but with little appreciation of the seriousness of the duty that they were undertaking.

There are also individuals who, throughout their lives, have never been required to exercise any degree of discipline or control over themselves. Of this group, it can be said, however, that many eventually make good soldiers, with help. An understanding talk on the real meaning of military responsibility, with accompanying, but not excessive, disciplinary action, will often be of help. Such counseling may sometimes be given effectively by the line officer himself.

The second group of AWOL's comprises those soldiers wh tend to resist all authority. These men generally have had similar problems in their civilian lives. Among these are also the individuals who seek to avoid or to run away from an uncomfortable experience, especially if it gives rise to fear. They include, for example, the soldier who may have reacted on the spur of the moment against an order or who, having been denied a pass, takes it into his head to walk off the post. This group of problem soldiers presents a more serious question as to their usefulness in any position in the military service. Disciplinary action alone does not usually improve their behavior, because of the fact that they go AWOL without thought of consequence, although as far as they are concerned, they have "a very good reason." These soldiers require study by a specialist to determine the degree to which they might be helped to overcome their problem and to make a good adjustment, or to decide whether they are a total military liability.

A third type of AWOL, somewhat similar to the second, are those who have no moral sense of responsibility whatsoever. These are men who frequently have long civilian court records, who have been engaged in delinquencies and perhaps crimes for many years. They believe only in the standards they set for themselves, and cannot be aroused to a feeling of duty or guilt over their misbehavior. They are nonchalant, pleasant in their outward manner, as long as they are not asked to do anything that they do not want to do. Alcoholism is a very frequent symptom in this group. Among this group may be found the majority of deserters. It is frequently necessary to discharge this group of AWOL's because they cannot be rehabilitated or affected by discipline or guidance in the military setting. If allowed to continue in the service, they will be a continual detriment to their unit, since they cannot be trusted or depended upon. They quickly cause a lowering of morale among their comrades.

A fourth and rather frequent reason given for being AWOL is encountered among those soldiers who have personal problems outside of the army; it may be the birth of a child, the illness of a member of the family, concern over a girl friend, or worry over any one of many other civilian

ties from which the soldier has not been able to make a separation. In this group, we find soldiers who have been closely tied to their homes and who have never developed a mature sense of independence. They will often use some tie with the outside as the reason for being AWOL, when actually this is their excuse for avoiding the hardships of military life. In most instances, it is possible to determine the exact nature of their problem, and by utilizing the proper resources within the command, such as the services of the mental-hygiene unit, they can be greatly assisted in developing a conscientious allegiance to their job. An agency such as the Red Cross can then be called upon to render practical aid and assistance to the soldier in helping him with his extra-military or civilian problems and maintaining contact between him and his family.

Because of the relatively high percentage of serious problems found among AWOL's and deserters, it would be advisable for the line officer to refer these men routinely to a military psychiatrist in a mental-hygiene unit, if for no other reason than to determine their mental responsibility and to give the line officer information as to whether these men may now or later present a serious problem to the service.

Peculiar Behavior.—The most difficult group of problems to describe are those which generally may be included under this heading. The phrase "peculiar behavior" is often used, and usually this is an indication that a more serious irregularity of personality is present.

The first to recognize "peculiar behavior" in a soldier would naturally be the group of men with whom he lives. He may be considered "goofy" by his associates, the butt of jokes. He may do many odd things, such as washing his hands continuously, or show a marked lack of personal cleanliness, odd body movements, and unusual posture. He may be considered absent-minded, preoccupied, gullible. He may have peculiar manners while eating or have extreme difficulty with such simple tasks as making a bed, sweeping, or clothing himself. On the other hand, he may talk about hearing voices, seeing things, having peculiar body sensations or "wild" ideas.

"Peculiar behavior" includes all strange conduct that

appears rather far out of line with what the average individual reasonably does. As stated above, in any group of men, such an individual will easily be noticed. He may come to the attention of the noncommissioned officer very early in his contact with the group; very often, because of his actions, he becomes the butt of jokes and ridicule on the part of other men. Whenever any of these symptoms are observed, the line officer should waste no time in getting the soldier to a medical officer who is a psychiatrist.

The "Goldbrick."—The soldier who is described as a "goldbrick" is not necessarily either a bad soldier or an intentional "goldbrick." "Goldbricking" may be the first sign of a nervous condition or of emotional maladjustments, as well as the method some emotionally disturbed soldiers try to make life easier for themselves in the army.

First to be noted are the goldbricks who are basically irresponsible persons. These are the kind who have found it possible, in civilian life, to get away with things, and who simply bring this kind of behavior with them into the army. They usually respond to discipline and close supervision, so that they may actually experience that goldbricking does not pay in the army. When this type of soldier is questioned about his goldbricking, he will usually give evasive, somewhat defiant or clever answers. His answers are usually different from those given by other types.

The second type of goldbrick is the one who has developed a specific resentment against the army. He may resent the type of work he has been given and show his resentment by goldbricking. Sometimes, a simple discussion with him about the way in which he was assigned his job, or a talk about its importance to the army, or an evaluation of the job in a new way, may be all that is needed to straighten him out. Again he may feel that the work is beneath the level of his capacities and training. This may or may not be the case. It is best referred for more intensive study.

Another type is the soldier who opposes any authority. He may have been overprotected in civilian life and has not adapted himself to army responsibilities, or he may be an emotionally disturbed person who cannot, without prolonged and professionally competent treatment, respond to authority.

In any case, if goldbricking is repeated, after attempts to change the situation have failed, study and observation by professional personnel should be sought.

A fourth category is the type of soldier who resents the army because it has separated him from his home and his loved ones and he cannot get along without them. He is unable to accept the army as he finds it, and in this evasive way, through goldbricking, he avoids his responsibilities. This type of soldier is in need of psychological guidance. A talk with him will usually reveal some childish feelings behind his behavior; here, again, professional judgment may be called on.

From the above, it will be seen that "goldbrick" is the name for soldiers who have a wide variety of difficulties in getting along in the army. In this connection, the first job of a line officer is to attempt to get some ideas as to what is back of the behavior; then, finding that the situation may require intensive study, he will refer the soldier to the mental-hygiene unit, where the specialists will deal with the soldier's problem as a whole.

The Chronic Sick Caller.—The soldier who goes on sick call with unusual frequency may do so (1) because he actually has some physical ailment that requires prolonged treatment at the infirmary or station hospital, though it may not be severe enough to remove him from active duty; (2) because his physical complaints do not respond to treatment or an organic basis for his complaints is absent; or (3) because he is actually malingering. In the first instance, the line officer would be in a position to help the soldier's treatment and complete recovery by consulting the medical officer and finding out how the soldier's ailment temporarily limits his ability to carry out certain duties. For example, the man who is being treated for some trouble with his feet might be given work that would not involve standing or walking until he recovers. This responsibility the officer would want to take, even if the soldier himself did not request any special consideration.

In the instances where a soldier does not respond to treatment or where no physical basis for his complaints is found, the officer cannot afford to ignore the fact that the soldier

complains. Any attempt to force the soldier to stop his complaints might only result in his expressing his difficulty in other ways, such as disobedience of orders, refusal to do work assigned, unauthorized absence from drill, poor school work, or even going AWOL. What the officer must bear in mind is the fact that modern psychiatry knows that a person may feel real aches and pains for which no physical basis can be determined. A common example is the soldier who has stomach trouble—*i.e.,* inability to digest food properly, frequent pains in the stomach, inability to eat certain kinds of food, nausea at the sight and smell of food, and even vomiting. Such complaints are often diagnosed by the doctor as "nervous stomach." This means that the stomach and digestive organs are free from organic disease, but that the actual discomfort and illness are due to a "nervous" condition of the patient which does not respond easily, if at all, to ordinary treatment with medicines. The cause of the illness, no less real than a physical condition that shows up in the X-ray, has been known to be an emotional state brought about by worry, fear, or anxiety over which the soldier has no control. Once this is understood, it becomes possible to realize how the person who may have had a nervous disposition before coming into the army could become so upset by the pressures of army life that he would actually develop a physical disorder. This condition may not have existed before, but now it definitely interferes with his doing his job. Professional treatment is necessary.

Other such complaints that may point toward definite emotional disturbances are frequent, persistent headaches, dizziness, visual difficulties, pain in back or limbs, heart sensations, poor sleep, jumpiness, uneasiness, and irritability. These are only a few of the more common conditions of which the soldier may complain and that are likely to incapacitate him as much as, if not more than, any other ailments. The line officer may often be in a better position to take notice of these symptoms than the medical officer, because the former is able to see the soldier under many different conditions and in many types of activity. It is something like the difference between looking for some automobile-engine trouble while the motor is standing still and while it is

in operation. The officer in this case is not only the driver of the machine; he must be able to detect any flaws in its working. If he cannot make the necessary repairs himself, he is responsible for getting whatever competent help is available.

The Disciplinary Problem.—A soldier may be expressing his unhappiness or resentment over his place in the army by disobeying orders. He may offer excuses when faced with assignments or with punishment. He may talk back, insult his superiors, or act in other insubordinate ways. He may interfere with other soldiers in the discharge of their duty. He may steal or damage property. Such cases may be minor or more serious, but it is clear that no matter what their degree, they have a bad effect on a company.

In the average case, the usual army remedy under the Articles of War may have the desired effect. In some cases, where there are further complications, punishment may serve only to aggravate the problem by clamping a lid on a "boiling kettle." What the officer has to ask himself in every instance is this: "Does this soldier do wrong because he does not yet know any better and has to learn 'the hard way,' or are there more disturbing personal reasons for his acting in such a manner? Is the soldier so emotionally 'unstable' or upset that he is not able to control his worries or fears of what will happen to him in the army or to his family because he is in the army? Is he 'stepping out of line' only since he has come into the army, or was he out of step in civilian life as well?"

Remembering that people act the way they do because of their background, an officer might examine the records that are easily accessible to him. The soldier's service record may show that he is a chronic trouble-maker. A review of his civilian background may reveal a basis for his behavior. Some exploration as to the kind of person he is should be made before it is decided what steps should be taken to make a better soldier of him. An example of this analytic approach may show how dealing summarily with a soldier can easily "miss the boat." Let us take the "normal" soldier who flies off the handle with an excess of patriotic zeal. If one understands what goes on in his mind and helps turn

his energy into constructive channels, he may become an asset instead of a liability to the company. It is such understanding that the psychiatrist can give the line officer in helping him to differentiate between the man who will continue to cause trouble and the one who can become a positive element in the company.

The Aggressive Soldier.—The soldier who most loudly states his hatred for the enemy and his desire to go overseas is not always the most reliable and may not always make the best fighter. The soldier who must tell every one about his eagerness for action may be "whistling in the dark" or giving himself a "pep" talk to keep his courage up. He may be expressing a picture of himself as he would like to be, while covering up his fear. Every one is familiar with the blustering bully who is found weak when the chips are down. These men are usually not to be relied upon for more complicated or more important jobs in action. They rarely have the balance or the backbone to think clearly under pressure. They are too tense and tied up inside to be able to size up a situation. They usually need a strong, guiding arm to help them along. They need special approval, commendation, and reassurance to keep them going. These aggressive soldiers need many very specific assignments to keep them occupied and active physical work so that they can burn up the energy they have to expend. They have a useful place in a fighting unit if they are given jobs that call for a great deal of activity without much responsibility. This kind of person may develop a loyalty to a strong officer who is willing to nurse him along, but if he continues to get into "jams," psychiatric consultation should be called upon for an opinion.

The Withdrawn Soldier.—The soldier who never "gets in the way" may also turn out to be the one who lags behind at the crucial moment. If a soldier stays by himself most of the time and just barely fulfills his job responsibilities, he may go unnoticed a long time before he is spotted. The line officer is very likely to miss him if there are many more active problems in the company. Yet this man may actually be very unhappy and worried about some personal problem for which he might receive help. He may be a shy fellow

who can be encouraged to make real friends in the company and in this way put forth more drive and energy in his work. He may be so depressed or so anxious about his job or about combat duty that he is likely to break down completely at a later, more crucial stage. The line officer can save many a casualty, physical and mental, if he "spots" those unsociable soldiers who may need personal guidance or special programs, or even discharge under pertinent regulations.

The Malingerer.—The chronic sick caller is very often misjudged as a malingerer. Malingering is rare in medical practice, perhaps because few lay persons have sufficient knowledge to feign symptoms, but also because the malingerer is defined as one who, with malice aforethought, deliberately tries to give the impression that he is sick in order to deceive or conspire, or to avoid an unpleasant situation or an obligation. When so used repeatedly, this behavior may indicate a lack of responsibility or of moral sense. In the army, it is rarely that a soldier deliberately resorts to this device or continues its practice successfully over a period of time.

If malingering is suspected, a medical examination should be requested immediately. The medical officer, however, can only make a statement as to the soldier's physical condition. Since malingering involves fraudulent intent or conspiracy, it becomes a question of fact, not a medical opinion. A courts-martial board would have to determine this on the basis of evidence and testimony. The psychiatrist should assist this board by his study of the soldier's motives, wishes, frustrations, and other attitudes and feelings, giving a report on his mental condition and responsibility.

Rarely would the line officer be able to marshal sufficient evidence to prove such a case. On the basis of the medical findings, therefore, an attempt should be made to establish the reasons for such behavior to see if a remedy is available. It may be that the soldier is the kind of person who, in civilian life, was able "to get by" or "to get away with" things and tries to bring this way of meeting an unpleasant situation with him into the army. Such a soldier may benefit from close supervision and discipline, so that he may find out that "goldbricking" doesn't "pay off."

A word should be said about the overconscientious soldier

who pretends to health or tries to avoid sick call or conceals a disability or injury. A neglected sore throat may quickly result in a fatality, or even in an epidemic. An officer should be as aware of the soldier who drives himself too hard—often to the detriment of the company—as of the malingerer who spends his energy avoiding details.

HOW THE OFFICER CAN HELP

The Group.—Good morale is a first aid to many potential mental casualties, just as good first aid improves group morale. The major part of the officer's working day is made up of decisions that affect his group as a whole. He is constantly called upon to maintain, under all conditions, a high spirit of coöperation and discipline. It is easy to understand how difficult this can be under the strain and tension of combat action. Weakness of morale that develops in a group of overworked or even inactive soldiers often threatens to take the edge off good training and discipline.

The special-services branch of the army and its officers have been charged with making available to camps, posts, and line officers many forms of activity and entertainment that are an aid to a high morale. An officer who is sensitive to the needs and interests of his men and who opens channels for them so that they may express themselves will often find a well-developed spirit in his unit.

Planned activities—such as discussion groups, a company weekly newspaper, and many other interests that a group of men may express—offer them healthful outlets. Instilling in the group the important idea that participation by the group and interaction in teamwork will make them strong and efficient will enable some insecure and fearful soldiers to get their bearings. For others, it will provide a release of tension, sheer fun, and good feeling, which will enable them to go back to their jobs with increased vigor. It has been increasingly recognized that active participation in group activities, particularly where a strong feeling of "belonging" to the group is involved, is often conducive to the emotional well-being of the individuals of that group.

The Individual.—It is not possible, however, to depend entirely upon a program of activities in order to maintain the

morale of every individual soldier in his daily functioning at his duty.

The general types of problem that the individual soldier may present have already been referred to. It is necessary for the officer to know how each man operates under all kinds of condition, what can be expected of him, where both his weaknesses and his strengths lie. The officer should be close enough to his troops, individually and through his noncommissioned officers, to be aware of any problem that may be slowing up one man or preventing another from fitting in just right. Early detection of the potential breakdown is important, since it may mean the retention of a useful soldier in the service. He will be helped to go on in his present job or in a position with less responsibility without a problem.

It cannot be overemphasized that the "how" of detection rests primarily in the closeness of the relationship between the line officer and the troops under him. Although an officer may have a fairly good understanding of the AWOL problem, the "goldbrick," the chronic sick caller, or other problems in his company, this will be insufficient unless he can have a close relationship with his men. By this, we do not mean that he become completely familiar with them in a personal relationship. What should be understood, however, is that he have a personal knowledge of each man that will enable him to evaluate the man's place in his unit and his performance at all times. It may not be necessary and in most cases it will not be possible for him to have this close relationship himself. From the point of view of the soldier, however, the noncommissioned officers are direct representatives of their commanding officer. They can reflect his interest and understanding of them.

The first step in observing men and learning about them is a thorough knowledge of the men's records. These records, which include the soldier's Form 20 card, his service record, and his 201 file, will reveal a wealth of information about his intellectual capacity, his interests, background, experiences, and capabilities. Often it will reveal information about physical disabilities that will save him from being assigned to certain types of work. Such records will also reveal a new man's previous disciplinary record and court-martial dispositions. Thus, right from the start, a line officer can

familiarize himself with those men in his company who may have problems in adjusting. Through his noncommissioned officers, he can take steps to observe his men closely, although this matter should be handled with the utmost care. It is important that the officer give every man an opportunity to fit into his company and to guide him where necessary without prejudice. The officer may wish to set aside some time during each week for his men to come in to discuss their problems. It is a well known fact that many soldiers avoid going to their commanding officers because they fear the stigma that might be attached to them. Many also may be blocked by a first sergeant who may have little understanding of the nature of his men. The fact that he needs help creates a serious problem to the timid or disturbed soldier. As a result, he may keep the problem to himself until he actually blows up and creates a serious problem for himself and his company.

The Noncommissioned Officer.—Relationships with the men and observation of them are especially dependent upon the noncommissioned officer. Selection of the noncommissioned officer, for example, should be made in terms not only of his initiative and his skill in getting things done, but also of his ability to understand men, their reactions to him, and his readiness to bring to the attention of the commanding officer men who are problems without fear of being himself criticized as an inadequate leader. Often the noncommissioned officer has the feeling that any problem that men show in his platoon or squad reflects upon his own leadership and is, therefore, unwilling to bring it to the attention of the company commander. This is an extremely unwholesome point of view and one that the commanding officer himself has the responsibility for preventing. Noncommissioned officers within a command will reflect their commanding officer's attitudes. A regular program of discussions might be held between officers and noncommissioned officers for reviewing the problems shown by various members of the company. Not only does this place the officer in the rôle of supervisor of the noncommissioned officer, but it brings to his attention those soldiers whose problems are serious enough to be referred to specialists within the army.

Often, a soldier's performance is not up to standard or he

is a behavior problem in one section or under a particular officer. More often than not, he has similar problems in another section or with another officer. For example, on the drill field, he may not listen to orders; in the barracks, he may not clean his bunk space; in his job, he may be listless. In general, the noncommissioned officer should try to help improve the soldier's behavior and training in so far as he can, but whenever the soldier presents a recurrent problem in any one area of his army adjustment, the officer should immediately learn how he is adjusting in other areas or under other officers.

Thus, there are many different methods an officer can use to detect the soldier who is a problem. The most important requirement of this job is that the officer realize that he is not alone in this tremendous responsibility. He is not expected to go beyond his own skill and ability in correcting all of these problems and he may call for the help of specialists provided by the army.

THE LINE OFFICER'S USE OF RESOURCES

Frequent reference has been made throughout this discussion to specialists within the army upon whom the line officer can call.

In the administration of his duties, cases will arise in which it will become necessary for the line officer to call in a specialist in order to deal with a problem presented by a particular situation, despite repeated attempts to stimulate the soldier "to get into step." It is a recognized fact that an individual soldier will operate at his highest ability to the extent to which he can give himself wholeheartedly to the job at hand. If he is "blocked" by worry or concern, and emotionally upset, he will be prevented from making the fullest use of his ability and may "crack up," so that he fails completely in all his activities.

A false idea that sometimes prevails is that a man who needs special attention because of his difficulties is either "queer" or "crazy" or a "psycho." Normal people may and usually do have problems in getting used to new situations in civilian life as well as in the army. Making the change from an old environment to a new and different one may take extra effort, like breaking in a new pair of shoes.

This is especially true when the change is sudden, abrupt, and almost overwhelming. Most people will be able to make adjustments without the need of individual supervision or special help, but there are others who are naturally slow and who react more slowly to change. These individuals need just a bit of extra support in becoming geared to the demands of the new life in which they find themselves. The sudden and unique change of living conditions for the soldier is obviously greater in most instances than the changes within civilian life.

Seen in this way, it becomes evident that the line officer's decision to send a soldier to another section for help becomes one of his duties and that he should maintain a constant interest in seeing that the soldier finds the help he needs to achieve satisfactory performance in the army. Or he should call upon a resource that has the command responsibility of deciding whether the soldier is able to stand the strain of army living at all.

The line officer cannot spend a great deal of time with one particular soldier because this will detract from his fullest attention to other aspects of his duties in the company, such as the training program or carrying out combat objectives. The types of puzzling problem that may continuously plague the line officer, in his job of training men for combat or in actual combat duty, require the attention of various "specialists," to be enumerated and described, with some suggestions as to the normal procedure and channels.

The problem may pertain to a difficulty in the man's assignment. Is the primary need a medical one? Is he in search of recreational activities? Possibly he comes from a religious background and is interested in chapel activities. Is there a "quirk" in this soldier's make-up that the officer "just can't make out" and that should be studied by a mental-hygiene unit? Is the man "too far gone" and should he be considered for discharge?

All these questions presuppose a working knowledge of the resources within the particular camp, maneuver area, or combat zone in which the line officer's unit is operating. Some echelons will have a variety of resources, while others may be more limited. It should be noted that the function of similar sections and specialists may change, depending on the unit's

nearness to the combat zone and whether it is a forward or a rear echelon. A commanding officer should make it his business to find out what service he can get for these problems in whatever command he happens to be.

How to Refer a Problem.—When the line officer decides to refer to a specialist a soldier who shows a physical, emotional, behavior, or training problem or any combination of these, he may have some idea of the type of complaint, as based on the soldier's story and on his own repeated observations. He will best report his observations in detail.

When the line officer has decided on the section or resource to which the man should be sent, he will have the responsibility of sending on a complete description of the man's problems, behavior, and attitudes, as they show themselves in the company's day-by-day activities. This should be done by a written statement sent through the existing military channels to the appropriate section. In special instances, if practicable, where it seems important to elaborate on the information, it would be advisable to talk with the appropriate officer in charge of the section or his delegated representative. In all this, it should be kept in mind that the basic purpose is to help the soldier find a solution for his difficulty in the best manner possible, so that the end result may be that he can fit into army life again in a more responsible and competent way. When the findings of this specialist have been obtained, they should be supplemented and sustained by whatever action is possible in the company. The officer should feel especially free to discuss these problems and the suggested measures with the psychiatrist.

The Resources.—There are several resources generally present in any command that can be used to facilitate the early handling of problems that are interfering with a soldier's performance of his duties. For example, certain men might be encouraged to utilize the activities and services of the *Special Services Division.* This unit is charged with activities connected with recreation, athletics, and the good and welfare of men. The lonesome, seclusive soldier may get a "lift" from participation in an art or language class, for example, so that he will find himself able to engage in other activities in a more active way and with greater "spark."

The soldier with a family problem is in no condition to apply himself fully to his army duties. Reference to the American Red Cross field director may enable him to get help for his emotional dilemma when he sees that his family is given financial or medical aid or personal guidance. The *American Red Cross* is a quasi-military organization that gives aid to soldiers with personal and family problems not directly related to the army. Since we know that a soldier who is worried about his family cannot keep his mind on his work, this service often helps an otherwise chronically upset soldier.

Other men, with religious interests and background, may find solace or stimulation in the counseling and religious instruction of the *chaplain,* who is responsible for the religious activity and spiritual guidance and instruction of the troops.

Where the difficulty of the soldier is determined to be specifically in his training-school assignment or job, which presumes that he is making a good adjustment in all other areas of army living, reference to the *Classification Section* is advisable. There he will be interviewed and considered for reclassification, if this is warranted, on the basis of his aptitudes, skills, and civilian experience.

The *infirmary* is obviously the section to which to refer soldiers with physical disorders, handicaps, and complaints. Where the infirmary officer finds that his diagnosis shows a need for further study or observation or for treatment beyond the scope of the infirmary's activities, soldiers will be referred to the mental-hygiene unit and, if necessary, to the hospital.

The Mental-hygiene Unit.[1]—A new army resource has been developed in this war—the mental-hygiene unit. Under the leadership and stimulation of the psychiatric branch of the Surgeon General's Office, this type of unit is now being developed and made available in the various branches of the army, extending from the lowest to the highest echelon. Although the use of psychiatrists in the army is not new and the present army organization gives continuous attention to

[1] See "The Unique Structure and Function of the Mental-Hygiene Unit in the Army," by Major Harry L. Freedman, M.C. MENTAL HYGIENE, Vol. 27, pp. 608–53, October, 1943.

problems of adjustment, the idea behind this unit is new to the military service. Its mission is to introduce preventive measures of mental hygiene in work with army personnel. Through the use of the clinical team made up of a psychiatric social worker and a psychologist, under the supervision and direction of the psychiatrist, it has been able to work toward the active adjustment of soldiers who otherwise might have been unable to fit into the army as effectively.

The unit, as an independent agency, is attached to the headquarters of the installation it serves. Its director is a member of the Commanding General's staff and thus is in a position to bring to bear all the resources of the army in meeting each problem. The number of the various types of personnel in the unit is determined by the size and needs of the installation in which it operates.

The clinical team in this unit is, as noted, composed of the psychiatrist, who must be a physician with special training and experience in the understanding and treatment of abnormal personality development and disorders; the psychiatric social worker, with his training in the understanding of human behavior and human relationships; and the clinical psychologist, with his training in the evaluation of the normal personality and his ability to measure specific capacities and aptitudes. An American Red Cross social worker, who provides additional assistance for handling the soldier's extra-military problems as they relate to his military adjustment, rounds out the staff. The skills of these workers are coördinated so that a most adequate approach to the study of the soldier's problem is possible.

Since the mental-hygiene unit is a part of army organization, it has access, through channels, to a variety of possible remedial measures helpful in dealing with the soldier's problem. It has direct liaison with the various units of the command—the adjutant, the chaplain, the special-service officer, the personnel officer, the intelligence officer, the infirmary, the hospital, the training officer, and so on. In this way, it serves as a centralizing agency, bringing together the many traditional army resources, as well as the latest scientific knowledge of the professions of psychiatry, psychiatric social work, and psychology, in the handling of each problem case. The line officer may call on the mental-hygiene unit

for assistance with the soldier who does not meet army performance standards. Some of these cases are: (1) soldiers who show problems in complying with company orders—*e.g.*, AWOL's, "goldbricks," cases of insubordination, and so on; (2) soldiers who are not responding to instruction in their training programs or daily duties; (3) soldiers who exhibit strange or peculiar behavior; and (4) soldiers who complain of frequent or unusual physical ailments that fail to improve with medical treatment.

The mental-hygiene unit employs selective methods adapted to the problem presented, since each problem is different in character and in degree of severity. As the individual difficulty calls for it, the unit is able to provide counseling, special psychiatric treatment, reclassification, or other remedy. Where further disposition is needed in regard to army standards, psychiatric and psychological data, together with a complete social history about the soldier, enable the unit to render opinions as to military suitability or to make recommendation for courts-martial proceedings and discharge.

The various branches of the army and the different echelons [1] within each service will present certain special types of problem. However, the factor of human personality, with which a mental-hygiene unit works, is fundamentally the same; wherever there are physical complaints, emotional upsets, or intellectual irregularities, this clinical team covers the problem most thoroughly and expeditiously. It is assumed that the line officer will acquaint himself with this first-aid job and be able to "spot" soldiers for whom he will want the services that a mental-hygiene unit has to offer.

Thus, it is clear that when the line officer detects problems in personnel that require more attention and help than is available within the limits of the company, the army provides additional resources and specialists who are trained and have professional experience in understanding and dealing with human behavior problems. These specialists can affect a soldier's ability so that he will operate effectively, if he has

[1] See "Mental Hygiene Clinics in Military Installations," by Major Harry L. Freedman, M.C., in the *Manual of Military Neuropsychiatry*, Chapter 39. Philadelphia: W. B. Saunders Company, 1944.

it in him. If it is not possible for him to become useful, the army wants to know that as well. In either case, greater military efficiency is obtained.

SUMMARY

First aid to the mental casualty is an important responsibility within the armed forces. Its purpose is to conserve and to salvage military man power as well as to prevent predictable breakdowns of soldiers at crucial stages of military activity. The line officer has the responsibility to take precautionary first-aid measures, as outlined in this paper.

Some of the most common physical, intellectual, and emotional symptoms found in the military setting that may be "danger signals" of more serious personality problems and disorders have been described. It has been shown how a study of certain soldiers, such as the AWOL, the "goldbrick," the frequent sick caller, and so on, can aid in their treatment or disposition. We have shown how first-aid precautions can affect and improve group morale, just as good morale renders first aid to many potential mental casualties.

Army resources are being increased and developed in all branches of the service. A description has been given of the manner in which the Special Services Division, the Red Cross, the chaplain, the medical officer, the psychiatrist, and, most recently, the mental-hygiene unit can be used. This last type of army resource is proving, in this war, to be a most effective channel for processing soldiers who have problems as a result of army requirements and pressures. The line officer's prompt use of these resources will work toward the maintenance of a high state of morale and will help to increase the individual's fighting efficiency as well as the spirit of his organization.

Observance of these principles will bring its own reward in terms of healthy soldiers striving for victory.

A PLAN FOR THE ORGANIZATION OF PSYCHIATRIC REHABILITATION CLINICS *

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AS an increasing number of veterans with neuropsychiatric disabilities return home, requests for information as to ways of organizing rehabilitation clinics also increase in number. The present paper is offered to meet the need for such information.

It is recognized that states and communities differ one from another and that psychiatric rehabilitation may be carried on under various auspices and with variations both in internal organizations and in outside relationships. For example, in Maryland, Arizona, and New York, the state vocational rehabilitation bureau is evolving rehabilitation plans. In Virginia, the work is guided by the state department of education. In Alabama, the state department of health has assumed the responsibility. In Washington, D. C., the city department of health has begun work. In Connecticut and Wisconsin, it is the state mental-hygiene society that has initiated activity. In Rhode Island, treatment facilities have been set up in the Providence Child Guidance Clinic. In Illinois, the department of public welfare is active and in Connecticut, a governor's committee. In New Jersey, initiative has come from the state hospitals. While the auspices may differ widely, the ultimate aim is the establishment of actual treatment centers. The suggestions offered here are

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intended to serve only as a general guide and to indicate the essential features of such an organization.

Auspices.—Rehabilitation clinics are being conducted or have been proposed for establishment in various communities under several auspices—community clinics, psychiatric hospitals, general hospitals, boards of health, social agencies. It is very desirable that the sponsoring agency be well accepted in the community, for at least in the beginning a clinic's reputation is apt to be as good or as bad as the institution or agency that sponsors it. The use that will be made of the clinic will depend largely on its acceptance by the public and particularly by the group to be served.

Relation to other Psychiatric Services.—Existing facilities should always be expanded before new ones are created by state or Federal authorities. There seems to us a definite advantage in establishing such clinics on a civilian basis not under the control of the armed forces. Psychologically, these men have severed their connection with the army. Successful treatment in many cases seems to result from the man's confidence in his civilian physicians. Such clinics can serve as more than mere treatment centers; they may form the nucleus for orienting the man into a whole new social life. A spirit of comradeship tends to develop among the patients because they are "in the same boat," helping to break down the feeling of isolation that many of them have when they come. The best policy seems to be to make the rehabilitation service to these groups a part of the general service available to residents of the community, or at least to all persons who have war-related problems of adjustment, and to recognize the special needs of veterans and rejectees by setting aside certain hours for their convenient and exclusive use. Such a schedule should include some evening hours, since many of these men work during the day and cannot attend day clinics without embarrassment and probably loss of pay.

Staff.—The staff needs of a rehabilitation clinic are those common to a psychiatric clinic—internist, psychiatrist, social worker, clinical psychologist, and, if possible, occupational therapists. The men who come to such a clinic are in need of a total, over-all survey. Frequently this has to begin with a thorough medical examination for purposes of reassurance.

Where a clinic is attached to a large general hospital, it may be possible to obtain the services of the medical out-patient department.

The psychiatrist is the central figure in the therapeutic situation; the psychologist assists him, but the social worker is apt to carry the brunt of the time demands. The occupational therapist is entirely optional, but she can serve a useful function as receptionist in offering various craft activities to the men who must wait for their appointments and in stimulating interest in crafts that can later be carried on by other agencies in the community. In turn, their observations on span of attention, planning, and so on may have diagnostic value.

The relationship of the three groups varies with different clinics, depending chiefly on the numbers of each that are available. Some clinics connected with psychiatric hospitals or out-patient services have five psychiatrists to three social workers and one psychologist. In these clinics the psychiatrist carries practically all the treatment responsibilities. Other clinics have three or four social workers to one psychiatrist and use a psychologist only occasionally. In these clinics the social worker not only takes the history, but does much of the psychiatric interviewing, under supervision and with frequent conferences with the psychiatrist. In some clinics psychologists are used extensively for Rorschach and aptitude testing, but others use them only to a slight extent or refer cases elsewhere for such testing service. Psychologists who are trained in clinical methods may be used for treatment where psychiatrists are limited in number or not available.

It is recognized that there are many areas where there will be few, if any, psychiatrists available. In such areas the work may have to be done largely by psychiatric social workers. The psychiatrist had far better be used for teaching and training purposes or for consultation on individual cases. What limited time he may have should be spread out over a larger group in teaching activities.

It is of course desirable that well-trained and experienced persons from all four professional groups be recruited for this work, for it requires speed, thoroughness, and smooth teamwork. In the large clinics it is desirable to include

one or more occupational therapists and perhaps a librarian and some one who is skilled in music.

Questions of Money.—Three questions of money arise:

1. Shall the staff be voluntary or paid? In most rehabilitation clinics that have already been set up, the staff members give voluntary service on a part-time basis. For example, two clinics in New York City operate on this basis, except that, in the case of the New York Hospital Clinic, one full-time social worker is paid. In other instances, the regular paid clinic staff merely uses one or two days or evenings a week for special rehabilitation work. In most communities in which efforts have been made to establish clinics on a voluntary basis, requests for volunteer time have met with excellent response from very busy people in all four professional groups, and their work has proven to be of paid-work quality. The only difficulty has been the loss of a few patients through failure to follow them up promptly when they began to decline or to break appointments. This, of course, may happen even in clinics where the staff is paid, when work is done under the pressure of heavy case loads.

2. The second question is whether the service should be free or paid for. Most rehabilitation clinics are giving free service and as a matter of policy have referred to private physicians or paid clinics those who are well able to pay for service and willing to do so. In several clinics men in the five-to-ten-thousand-dollar salary bracket who have come in search of help have indicated their desire to pay for the service. Such patients are normally referred to psychiatrists in private practice or to recognized paid clinics. In the rehabilitation clinics there is little evidence of any pronounced therapeutic value in a fee or, conversely, any therapeutic handicap in free service.

3. The third financial problem concerns the obtaining of such funds as are needed to establish and maintain the clinic. Considerable money is needed if the staff is paid, and even if the staff is volunteer, some money is needed for telephone, supplies, and secretarial help. At present, rehabilitation clinics are variously supported—by the sponsoring community clinic, hospital, or social agency; by a foundation interested in mental hygiene; by a mental-hygiene society;

by public departments of health or welfare; by interested individuals; and so on. No sure source of funds can be suggested. It has been reliably reported that some state departments of health have unused balances (by virtue of staff shortage, or arrested or postponed projects) which conceivably may be used partly in rehabilitation work, especially where such departments are much interested in mental hygiene or have a subdivision devoted to this.

It should be noted in this connection that the Barden-La Follette bill and the plans of the various state bureaus of vocational rehabilitation make provision for the payment of fees for examination and treatment of those eligible for vocational rehabilitation.[1]

Thus rehabilitation clinics may rightly accept a limited amount of income through fees from that source. Communities cannot look to state rehabilitation bureaus to establish clinics, for while they may purchase services and employ professional staff to administer the programs, they are not authorized to establish new treatment facilities.

Leadership.—The first requisite for establishing a clinic is one or more persons or an agency or institutional staff who have genuine convictions as to the need for and the practicability of a rehabilitation clinic, and who will persevere until they succeed in organizing one. In different instances, leadership has arisen from psychiatrists in private practice, from psychiatrists engaged in clinical or educational work, or from executives of mental-hygiene societies or social workers in key positions.

Advisory Committee.—It is desirable to arrange for an advisory committee in order to create a receptive mood for the contribution of the rehabilitation clinics and to interpret the meaning of psychiatric casualities to the community. The members of this board should represent all the areas of importance in the task of rehabilitation. They should advise in fields where psychiatrists, psychologists, and social workers are less experienced. They should learn from the clinic

[1] Civilians or veterans with non-service-connected disabilities are eligible if (a) medical diagnosis indicates a handicap that prevents or appreciably limits gainful employment, and (b) if the prognosis indicates that medical or other services or vocational retraining or both will result in improvement in employment and work efficiency.

set-up the meaning of psychiatric manifestations and the needs of the men for community resources. They should interpret to the outside community what they have learned from the professional group, as their voices may be better heard and their recommendations better accepted then those from the psychiatric field. It is most important that there shall be a close contact between the outside world and those who treat the men to help in their recuperation.

The members of this advisory committee can open channels and make contacts for the clinic patients. They should include representatives of the major religious groups and their welfare interests, of the United Neighborhood Houses and their recreational groups, of family and group-work agencies, of educators and vocational counselors, of United States and private employment concerns, of industry (management as well as labor), and of bodies for community planning, such as welfare or civic councils. The arts and music centers should be represented as well as libraries and museums.

Whatever the clinic will need from the community should be discussed with this committee, and cases of individuals difficult to adjust in their social contacts should be brought before them. Their advice will be invaluable. Such an advisory committee should meet at least once a month and the psychiatrist and representatives of the staff should be present. Such meetings not only bring practical help to the clinic, but also result in better psychiatric orientation within the committee, which in turn results in increased public understanding and increased effectiveness in referring to the clinic those who need the service.

Selection of Location.—The selection of the location of the clinic will depend on several factors. The sponsoring agency very often wishes to house the clinic at its own establishment. The clinic should be conveniently located with reference to transit and bus lines and other travel facilities. As already indicated, it is very important to associate the clinic with some agency, department, or institution that is well accepted in the community, and probably one that is in a place to which people are accustomed to look for help of a kind that does not stigmatize them. It would seem to be a mistake to shy too much away from designation of the service as

psychiatric in type. The individual man will know soon enough that he is being interviewed by a psychiatrist, and there is no necessity to hide this fact. The time has come for psychiatry to take a place in the open and to be accepted by communities as a source of help. Wherever the clinic is housed, there should be adequate provision for private interviewing rooms, a comfortable reception room, and the other usual facilities needed for clinic operation.

Recruitment of Staff.—Ordinarily psychiatrists can best be recruited by a psychiatrist and social workers by a social worker, regardless of the particular organizational connections of either. Where initiative is taken by the psychiatric group, the needed social-work assistance can often be obtained by workers through the local council of social agencies or its equivalent. The community-organization aspects are apt to be best handled by a worker whose work is in that field.

Internal Organization.—The organization should be kept exceedingly simple, since the clinic serves people who are already distressed and tense and unable to deal with complicated procedures.

Cases may be referred from local draft boards, state Selective Service boards, private physicians, U. S. Employment Service, and social agencies, and in many instances the men will have read or heard about the clinic and will spontaneously seek help. It is important that as soon as possible after the initial reference of the case, the man be seen by a social worker at the clinic. His anxiety at coming into a clinic is alleviated after a friendly contact. The initial history can be taken, and fewer cases will be lost.

Great care is needed in preparing the man for reference, since about 20 per cent of the cases referred do not turn up. The man should not be overly persuaded, but if he shows interest in seeking help, he should be given very explicit directions as to how to get to the clinic. An appointment system is desirable, otherwise unscheduled cases arrive without preparation and without staff to take care of them, and an opportunity is missed since the man is not likely to return.

It is important that the registrar be a well-trained social worker. She has the first contact with the patient, and she will recognize conditions of extreme anxiety, fear, and

depression. She can bring these cases as quickly as possible to the attention of the physician in charge, so that existing tensions do not develop further. The patient's initial response to a welcome in the clinic will determine to some extent the failure or success of treatment. Every patient should be known to a social worker; the registrar should introduce him to her. The routine procedure of filling out a clinic card is used for the purpose of acquainting the patient and the social worker with each other. In this first interview, a history may be taken or the clinic function as a whole may be explained to the man, general questions answered, fears alleviated. In turn, the social worker introduces the patient to the physician and to the psychologist, the occupational therapist, and the librarian.

Contrary to the practice of the average clinic, in the rehabilitation clinic it is well to encourage patients to meet one another and to engage in conversation at other activities. Members of the families who may accompany the patients are also drawn into activities. These conferences are very helpful in removing the patient's sense of isolation and in helping to establish a feeling of acceptance and approximate normality.

At least one clinic has undertaken group therapy with a group of anxiety-type patients. This has been done not only to save staff time, but also because there is therapeutic value in the group situation. Decisions regarding patients may be made either in total staff conference or in separate conferences of the physician and social worker who are working with the patient.

Records.—Records should be brief, but adequate. Social histories should include only pertinent information since the psychiatrists are almost certain to have very limited time for reading records. The psychiatrist should keep his own history. This can be either written by him or dictated to a secretary if one is available. The first interview should be recorded at sufficient length to orient any other physician or social worker who may have to take over the case. Progress notes can be brief, but should record the new material obtained in therapeutic discussions. Diagnosis, treatment plan, social planning, and a final evaluation of the treatment

results should be recorded. At least in the early months of operation, records of the time expended should also be made.[1]

The patient should be given an appointment card indicating time and hour of his next visit and his physician's name.

A filing system is necessary for the recording of the patient's record and should contain pertinent information.

The actual clinic record needs a face sheet.

If the clinic plans to incorporate a research project as part of its activities, it is well to keep a time chart of the actual amount of time given to each patient by physician and social worker.

Because of our own need to accumulate specific information about each patient, we at the New York Hospital Rehabilitation Clinic have prepared a research chart, to be filled in by the individual physician during his course of treatment and completed at the time the case is closed.

Treatment.—The type of treatment to be employed will vary with the individual psychiatrist and his own orientation. Our experience has been that an occasional patient can be oriented toward recovery in a single consultation, with guidance as to planning. For another group, making up about one-fourth of the cases, brief psychotherapy, aimed at the discussion of resentment, the ventilation of traumatic emotional experiences, together with active social-service help in making social contacts and finding appropriate employment, brings about speedy improvement. A third group, about one-fifth in all, consisting of depressions and hysterical and hypochondriacal reactions, need repeated therapeutic interviews. With the second and third groups, group-therapy methods can be adopted. In other cases, where the problem is deep-seated and was well established prior to induction, intensive and prolonged individual psychotherapy is necessary. Individual policy must decide whether these patients should be carried for treatment. The largest number of the disorders are of a chronic type and are not well suited for treatment in a rehabilitation clinic. Such patients are in need

[1] Copies of the forms used in the New York Hospital Rehabilitation Clinic can be obtained without charge by writing to Dr. Thomas A. C. Rennie, director of the clinic, 525 East 68th Street, New York 21, N. Y.

either of hospitalization or of protracted psychotherapy in established out-patient departments, where such exist.

We feel that rehabilitation clinics should not duplicate existing out-patient services for psychiatric treatment. Unless some time limit as to the amount of treatment available is set, there will be many patients who will return regularly for weeks or months. Very often these are cases in which the problems were clearly established in civilian life long before induction and the responsibility for their treatment should not devolve upon a rehabilitation clinic. Many of these men will be employed and are quite able to pay for adequate treatment by private psychiatrists.

It has been found helpful to conduct an evening review of new cases, at which all the medical staff officers, psychologists, and social workers meet to hear a brief report about the case from the psychiatrists and to decide upon the type of therapy needed and the amount of social-service activity to be given to the patient and his family. Through this means the individual workers share in the total experience of the cases of the day.

Follow-up.—There is need also for a follow-up plan to evaluate the results of therapy and to make sure that patients who may inadvertently have dropped therapy have not been lost sight of. A follow-up letter or a social worker's visit should ascertain the reason for the termination of the treatment. Sometimes it helps also to persuade the patient to continue with the treatment.

The foregoing plan for the organization and operation of a psychiatric rehabilitation clinic can be adopted with variations for different areas and problems. As described, it has proven simple and effective in actual operation.

THE PSYCHIATRIC SCREENING PROCESS FOR SELECTEES

SOME OBSERVATIONS MADE AT U. S. ARMED FORCES INDUCTION STATION, KALAMAZOO, MICHIGAN

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THE psychiatric screening of selectees for military service prior to induction has been generally accepted as very necessary in the building of an effective military force. It became necessary to develop this aspect of the general physical examination in the last war—to consider not only the physical aspects of the men, but also the mental aspects and the general personality make-up, in order to eliminate the mentally defective and other individuals who could not, in all probability, withstand the stress of actual combat. This is even more imperative in the highly mechanized warfare of to-day. It is especially important when the nation is taxed to provide man power and the pressure becomes great to lower standards and accept all varieties of man, and when, as a consequence, methods of examination that would result in the elimination of men are looked upon with less favor.

If we consider men not merely numerically, but in terms of effectiveness for the job to be done, the total psychiatric rejection rate, though it has been high, should obviously be no cause for alarm, for only the unfit are eliminated. The lessons of the last war should be kept constantly in mind. Hundreds of millions of dollars were paid out to claimants with neuropsychiatric disabilities and in the costs of hospital and domiciliary care, national homes, and civilian state hospitals, and much of this could have been avoided had many of these men been eliminated prior to service.

Furthermore, the rejection rate prior to induction, taken as a figure by itself, is of little significance. It becomes

important only when we compare it with the discharge rate from the services for neuropsychiatric and related conditions. We should ask ourselves, not what is the rejection rate, but whether the discharge rate has been materially reduced as a result of the psychiatric screening, as compared, for instance, to the figure of the last war or to the figure of those units in the army in which no preliminary screening of this nature was attempted. Have we fewer psychiatric casualties than formerly?

It is not possible as yet to answer these questions fully, but future studies will, no doubt, affirm the value of the initial psychiatric screening. Despite the present lack of sufficient statistical data, the fact that so many unfit and potential casualties are screened out is, of itself, a tribute to the foresight shown in the establishment of the pre-induction psychiatric examination.

What are some of the problems and difficulties of this important procedure? What might be done to make it even more effective? It is with these questions in mind that we attempt here to review the screening process after two years' experience at Kalamazoo, Michigan.

The purpose of the entire examination procedure for selectees, as set up by the army, is to provide a rapid means of securing for service only those individuals who are physically and mentally equipped to be soldiers, and who will be able to carry out the numerous tasks of a military nature that must be done.

The job of the neuropsychiatrist (with the aid of the now included psychological personnel) at the induction station is to evaluate the psychological and neurological make-up of the selectee who comes before him in the course of a general examination from the point of view of his fitness as a potential soldier. He must eliminate or exclude, as far as is possible, the psychologically unfit and unstable, and retain those who will not break down in the service or who will not show inaptitude or evince their inability to adjust to the army by becoming serious problems in military misbehavior. He must screen out, and thus spare the army from having to deal with, those whose presence in the army would lead to military ineffectiveness, loss of morale, eco-

nomic waste, and much lost time and effort in the way of training.

It is quite obvious that the presence in the army of men with various personality disorders constitutes a serious handicap to the effectiveness of the units of which these men are a part. A great number of fit men would have to be immobilized to care for them. In the event of actual breakdown, valuable beds would be kept occupied and more medical personnel would be required, to say nothing of the creation of many problems for the military police, and the necessity of instituting methods of dealing with military misbehavior and disciplinary problems whose roots are basically in psychological maladjustment. Also to be considered are the unprofitable expenditure of time and money on the training of these men, as well as the unnecessary payments later for disability pensions, rehabilitation procedures, and hospitalization.

The psychiatrist must be alert also to keep out those for whom the army offers a ready and convenient solution for serious social-maladjustment problems. The army is sometimes used as a "way out" by persons who have had difficulties in adjustment, or as an escape from facing personal or community problems. All that actually happens in such cases is that a difficult problem case is passed along to the army, with the hope that getting rid of him will solve the problem, in a sort of "out of sight, out of mind" way. It must be remembered that the army is in no sense an agency or "dumping ground" for the care or utilization of misfits. It was not meant to provide asylum for the feebleminded, the ne'er-do-well, or the confirmed criminal. Furthermore, it is not primarily a place for the cultural advancement or occupational training of the vocationally unfit or handicapped. It is neither a guidance clinic nor a place where emotional problems are solved. There is little room in the army for the individual who is already a serious problem to himself, his family, or his community; for if he is already maladjusted, army life would probably intensify his difficulties.

At the induction station, at the very inception of building the army, the first contact with the selectee is made. Under the pressure of great numbers, and often with limited personnel, important decisions and evaluations as to psycho-

logical fitness for the army must be made. Several very important considerations obtain at this point. It must be remembered that most of the psychiatric examiners on the induction boards come into the army from civilian practice, or with a background of state-hospital experience. Few have any real conception of what army life to-day actually entails. Their knowledge must be derived from secondary sources, until they gradually become oriented as to what the army actually wants in the way of personnel.

This lack of initial army orientation for induction work obscures and handicaps the psychiatrist's ability to evaluate with adequate military acumen the men who come before him. He is, of course, well acquainted with actual nosological disease entities, for which his civilian experiences has adequately prepared him, but this alone is not enough. This would indicate that perhaps civilian psychiatrists who come into army induction stations as examiners should be given a short preliminary orientation, so that they could obtain a rather clear-cut picture of what is actually wanted of them, and a survey of what the army as a whole does—how it handles its personnel from inception to discharge, including the training procedures. In this connection, too, it would be helpful to get the point of view of line officers who have had much experience with men in army routine. Such a procedure would be of aid to the psychiatrist, and lend a certain uniformity and objectivity to the examinations.

The selectees are a rather heterogenous group, except for broad general characteristics relating to age, dependency, and, perhaps, marital status. They do not represent some special or separate group, but are a cross-section of the male population—the farmer, the laborer, the skilled worker, the miner, the woodsman, the clerk, the professional man, the student, and so on. Each one comes to the station a distinct personality, with a background, abilities, disabilities, aptitudes, and handicaps that are his alone. He comes with practically no authenticated information about himself excepting that which he himself brings or can give us. Yet despite the pressure of large numbers, and the stress and limitations of mass examinations, each selectee must be given as careful and deliberate a study as is possible, and all findings must be recorded as part of a permanent record.

Here, again, several factors hard to control make the psychiatric examination particularly difficult. One of these factors is the condition of the selectee who comes for the examination, affected, perhaps, by sleeplessness, a long and fatiguing trip to the station, the excitement of leaving home and friends, celebrations and parties, or alcoholic overindulgence. Another type of difficulty that taxes the skill and ingenuity of the psychiatrist is the attitude of the selectee toward the examination and military service in general. As a rule, he is curious about the state of his health, and anxious to be found fit and to get into the service—but not always. Fortunately, however, many more are disturbed by being rejected than are upset by being accepted.

The attitude of the selectee varies considerably, and must always be taken into consideration in the total evaluation. It must be remembered that the attitude of the selectee is not the same as a patient who comes to the doctor seeking aid voluntarily. The selectee is for the most part "selected"; it is, therefore, often necessary to elicit information of a highly personal nature and so charged with emotion that it is uncovered and imparted with difficulty. It is given with great reluctance, if at all. This means that the psychiatric examination has to be comprehensive, yet succinct. The method used by the examiner must be such as to get quickly as much information as possible, taking a cross-section of the entire personality, such as general health, marital status, occupation, recreation, sex life, police records, schooling, and so forth. Time must be taken to survey these areas of the personality; otherwise important leads will inevitably be overlooked.

An outline such as the following might be used and would aid in the standardizing of the examination. Since no two men approach the psychiatric examination in just the same way, however, a rote following of the outline is not indicated; it should be adapted to the individual examiner. All the areas dealt with in the outline, nevertheless, should be explored. The examination envisages the selectee as he approaches, in the nude, the psychiatrist in his private examining cubicle. The examination in the nude has certain merits that would bear mentioning. It is indeed surprising how defenses are shed along with one's clothing! Also, the

examination, so conducted, enables the psychiatrist to check muscular deformities and endocrinological conditions.

The selectee is told to do the following:

1. Stand with your feet together and hands extended in front of you.
2. Spread fingers apart. Turn hands over, back again. Make a fist. Spread fingers apart again.
3. Close eyes. Touch nose with right index finger; with left.
4. Turn around.
5. Sit down. (Pulse is examined.)
6. Patellar reflexes and abdominal reflexes are examined.
7. Pupillary reflexes are tested, eyes are checked for nystagmus, and mouth and tongue are examined.

This much of the examination reveals quickly such matters as general appearance, gait, posture, Romberg, coördination, tremors, fibrillation, nail biting, important reflexes and ocular movements, tachycardia, vasomotor phenomena, muscular atrophy, and paralysis. The physical appearance of the selectee tends to bias the examiner as to the adequacy or inadequacy of the individual. While general physical appearance, hygiene, robustness, and so on, are important, they might be misleading if considered alone as a sole guide. Therefore, in all cases, the complete historical survey of the selectee is important.

Next follows a general line of questioning, in a rather matter-of-fact, simple, conversational style:

Personal identification: How old are you? Where are you from? Citizen?

Medical history: How do you feel? Always been well? Any complaints? How long since you have seen a doctor? Taking any medicine or drugs? Any heart trouble? Stomach or kidney trouble? Bed-wetting? Any headaches? Noises in head? Dizzy spells, fits, fainting spells, or convulsions? Ever been unconscious? Have a skull fracture? Any rectal or prostate trouble? Sleep well? Good appetite? Ever have a nervous breakdown? Been in a state hospital? Any venereal disease?

Psychosexual history: Married? Go with girls much? Sexual experience? Masturbation? Homosexual inclinations or experiences?

Educational history: How much schooling? How old when you left? Why? Any special training? Like school?

Occupational history: What did you do after leaving school? Are you working now? How long? Steady? Ever miss any time from work? Why? Like your work? Get along with the boss and the fellows?

Recreational data: What do you do after work and on week-ends? How do you have a good time? Go out much? Make friends easily? Do you like to go out alone? Do you get lonesome? Restless? Like to read a lot?

Emotional make-up: Ever get the blues? Discouraged and dissatisfied? Crying spells? What do you fear and worry about? Personality

change? Are you self-conscious? Do people make fun of you? Call you names? Irritable? Do people say things about you? Are you very religious? Pray? Every imagine that you hear voices? Religious objection to the service?

Family history: Ever been away from home before? How do you get along with mother and father? Any responsibilities? Contribute to family support? Does any one pick on you? Any epilepsy or insanity in the family? How do you feel about leaving home?

Legal history: Ever been arrested? Jail sentences? Juvenile record? Probation?

Attitude toward service: How do you feel about getting into the service and leaving home and job?

By these, or similar questions, it is possible to obtain a longitudinal and a cross-sectional picture of the person, with a view to eliciting his general maturity, occupational adequacy, general intelligence and ability to learn, judgment, insights, relationship to others, sexual adjustment, seclusiveness, hypochondriasis, stability, or any actual abnormalities such as delusional trends, hallucinations, and loss of affect.

It is important to emphasize that just asking questions is not sufficient. The examiner must be alert, must follow up all leads, and must thoroughly investigate discrepancies in responses or questions answered in a hesitant or emotional way. During the questioning, one should note not only the response and its relevancy, but also the man's general demeanor, appearance, affectivity, attitude, somatic manifestations, and vasomotor reactions.

Also to be considered, especially where the selectee, for various reasons, is reluctant to leave home or job, is the factor of conscious or unconscious exaggeration. Under these circumstances, actual malingering may be expected, and it serves to make the general evaluation very difficult, aside from the question whether such a person should be accepted and given the "test" of service, or considered unsuitable precisely because of his dissimulating or "goldbrick" attitude. Moreover, the attitude of the psychiatrist toward a selectee suspected of "trying to put one over" militates sometimes against an objective consideration of the total personality. Frequently, when this is the case, the selectee is accepted, not on his own merits, but perhaps as a "punishment" or retaliation for his arousal of a hostile or aggressive attitude in the examiner.

Such defensive reaction, fortunately, occurs only occasion-

ally. This type of emotionalism, which may occur in the examiner, can be guarded against in doubtful cases by a double check, which could be made by two or more examiners conducting independent examinations and then holding a consultation on the case in question.

To call a condition "malingering" is often to acknowledge that the examiner has some difficulty, or "peeve," perhaps, that prevents a clear-cut evaluation because of the aggression that may be inadvertently aroused by the selectee. On occasion, in the case of certain psychoneurotic rejections, when an opportunity occurred for a subsequent reëxamination, the legitimacy of the supposedly hypochondriachal complaints was proved by presentation of actual physical findings disclosed by the private physicians of the selectees, such as fistula-in-ano, chronic prostatitis, cholecystic disease, and so on, which the army examination failed to disclose, but which, when treated, cleared up the majority of "hypochondriachal symptoms." These individuals, it seems, had a valid basis for their complaints, which again emphasizes the caution that all complaints should be regarded carefully.

Often, too, if the so-called malingerer is given adequate opportunity to "save face" by not being too rigidly held to his statements, the true state of affairs and the basis for the dissimulation can be elicited. There is sometimes an advantage in a sort of anticipatory desensitization by an understanding, tolerant, and accepting attitude on the part of the examiner. When facing this non-censoring attitude and kindly assurance, the selectee is more apt to forego the defenses of righteous indignation and stubborn maintenance of his inaccurate story than if treated with suspicion, told of discrepancies, and handled sternly. Providing him with a "way out" tends to create a more coöperative attitude. This is especially true, for example, in the case of homosexuals, who may be ashamed and fearful of disclosing their invert tendencies. Furthermore, it is questionable whether a person without a vital interest in the war aims will make a good soldier unless his morale can be stimulated and developed and all his energies enlisted in the war effort.

In the last war, as soon as patients suspected of malingering were treated as such and their symptoms removed, they were returned to the front, where they once more became

ill.[1] Individuals who exploit their illnesses are apt to be difficult problems from a military standpoint, and at the induction station this always raises the question: Are we dealing with a psychoneurotic or with a malingerer who purposely exaggerates his symptoms? Certainly, these two types are not mutually exclusive, and it becomes necessary, in such cases, to make a very careful evaluation of the man's total personality and situation before a decision as to military utility can be made; frequently, indeed, only the "test of service" will decide the issue.

Another type of evasion that is difficult to detect is the positive kind that occurs in some epileptics who deny all previous unconscious episodes because of a desire to get into the service. Unless an actual attack is witnessed or other corollary data is available, these selectees will be inducted and cannot be screened out at the induction level.

These considerations make us realize that more than just cursory examination is required. Often, an examination or a reëxamination at the end of the day or the next day, or even after a period of deferment, with a request for further data from the Selective Service board, has been found to be helpful and necessary. Where no objective findings are in evidence during the examination, the availability of adequate social-service data, hospital records, affidavits from family physicians—especially as regards epilepsy, nocturnal enuresis, psychopathic state, migraine, and so on, would be invaluable.

Another untoward factor in the induction procedure is the speed with which the examinations must be made to avoid "bottle necks." The pressure on the examiner tends to encourage superficial, hurried examinations, and also makes for undue strain upon the critical judgment of the psychiatrist. A possible solution for this problem is more personnel to facilitate the examination procedure. It goes without saying that any authentic information concerning each selectee would immeasurably facilitate this study, were it available at the time of his examination.

In order to build an effective army, the psychiatrist must necessarily act to screen out the unfit. The problem, however,

[1] See *The Problem of Lay Analysis*, by Sigmund Freud. New York: Brentano's, 1927. p. 121.

is not just the negative one of keeping out the unsuitable; it also involves the positive question: Where will this individual best fit into the service? It is a problem of "selecting in" rather than of "selecting out" alone. This means that the induction examiner must be able to assay the military assets and liabilities of the selectee and must have a good understanding of what the army will expect of him, as well as of what the selectee will be confronted with in army life. It means knowing the positive qualities that make a good soldier, not just the disqualifying features. It means knowing just where he will fit in, or can be made to fit in, for the good of the army, and where he can function best as a soldier. This is by far the most difficult aspect of the screening, because it involves, also, a classifying and placement process.

At present an excellent and objective procedure is used at the reception centers some time after induction has taken place. Here the men are given vocational tests and interviews and intelligence tests, and a serious attempt is made to allocate them to the branches of the service and to positions for which they are intellectually, vocationally, and educationally suited. This process often effects a less traumatizing transition to army life, as there is apt to be less opportunity for maladjustment to develop because of poor vocational placement.

From this classification center, the men are assigned directly to units or to the various replacement training centers for further education and training. In this way, an attempt is made to assign each man to the branch that can make the greatest possible use of his skills, abilities, and aptitudes in terms of army needs. If sent to the replacement training centers, an attempt is made to assign each soldier to the type of training that he can most readily absorb. In addition, reclassification and reassignment is made possible in the army, at these centers, and in the separate units, so that use can be made also of interests, military experience, aptitude, and leadership ability that is there disclosed, or possible errors that may have been made previously can be rectified. At these centers, too, men may be sent to special training units, to correct illiteracy and so forth.

Thus by the use of these procedures and training schools, the whole program is made a positive, rather flexible pro-

cedure whereby it becomes possible for a man to be placed in a position where he can function to the full extent of his capabilities. As a last resort, of course, discharge can be effected, in the event that inaptitude or lack of capability proves so great a handicap that the man can be of no value to the army. Under present arrangement, however, where the classification procedures and results are not available, the induction personnel must rely on the general rule that if a man has adapted well in civilian life (as disclosed by the psychiatric interview) in terms of schooling, job, marriage, police record, and so on, he will in all probability do well in the army. The induction psychiatrist can feel reasonably secure about this, especially since provision has already been made in some replacement training centers for the further detection and proper disposition of accepted selectees who show signs of abnormality, thus making the screening process even more effective.[1]

The acceptance of a potential psychiatric casualty not only would handicap the army, but also would be disastrous to the man himself. This is especially true in the case of the selectee who is now managing to get along fairly well in the community, but who, if inducted, would break down. The problem is not only one of ineptness or unfitness for military service alone, but also a matter of the fitness and vocational usefulness of the man as a civilian, a fact that is vital in terms of needed man power. Rejected men in some instances are not merely eliminated from the war effort (*e.g.*, mild psychoneurotics, latent homosexuals, and so on), but are retained for work that they can perform at their capacity level in the community—a point that should be emphasized to those who are so rejected and who show some concern about their status. In this way, more serious breakdowns may be prevented; the man can maintain his self-respect and be a useful, patriotic citizen contributing to the winning of the war; whereas, if he were inducted and a subsequent breakdown were to follow, he not only would be lost to the

[1] See "The Rôle of the Mental-Hygiene Clinic in a Military Training Center," by H. L. Freedman. (MENTAL HYGIENE, Vol. 27, pp. 83–121, January, 1943.) See also "Neuropsychiatric Program for a Replacement Training Center," by L. E. Stillwell and J. Schreiber. (*War Medicine*, Vol. 3, pp. 20–29, January, 1943.)

war effort and to the community, but also would be a burden upon it.

Mass psychiatric screening has disclosed various existent morbid conditions that were in many cases previously unrecognized, and that, in some instances, would respond to treatment. The screening, however, has only served to focalize the problem. It did not create it. It has only made it more visible in the community. We must remember, however, that in considering a total psychiatric rejection rate, this total, when analyzed and broken down, represents many different kinds and degrees of unfitness, and that when a person is rejected, the prime consideration is his unfitness for the army. The guiding question is, Will this man make a good soldier?

It is obvious that the definitely psychotic, the pre-psychotic, the mental defective, the chronic inebriate, the epileptic, and the constitutional psychopath in all its categories, as well as the obvious psychoneurotic, must be rejected as unfit. They were problems prior to mobilization, and they will probably continue to be so.

There is, however, another large group of selectees often rejectable for army service that must be evaluated—the so-called "inadequate personalities," in whom constitutional weakness seems to predominate. These men frequently manage to get along in their communities among their friends and in the protective presence of their families. Perhaps they led a much handicapped existence, and were making, in many instances, only a marginal type of economic and social adjustment, but they were not community problems as such. These individuals, despite their personality handicaps, often manage to effect a somewhat superficially satisfactory adjustment in civilian life. On the other hand, taken away from their sheltered and protected environments, they may be unable to adjust to the army, where the conditions of living of necessity are less flexible and more impersonal, and where self-sustaining resources in the person, capacity for sublimation, self-control, and ability to make new friends and develop new parental surrogates, and to form new dependencies and ties, are necessary.

In evaluating such men, the realization of what going into the armed forces means to the selectee must be kept in mind.

It means a separation from parents, family, and friends. It means the sudden insecurity of emancipation from home. It entails a need and a capacity to understand, to take and to execute orders, to submit to authority and discipline, to adapt to new and strange people, duties, and surroundings. It means a capacity to learn new ways and to maintain morale under varied conditions. It means the ability to subordinate one's own wishes, to accept regimentation and restrictions, to do without the usual comforts, yet at the same time to be aggressive and possessed of enough stamina and initiative to care for one's self and get along in a group. It means equanimity and imperturbability under the most untoward conditions. Often, changes in basic habits and routines of eating and sleeping must be effected. In short, a soldier must be adaptable and be able to become a useful member of a military team—an integral (though often a minute) part of a group.

In addition to all this, the selectee psychologically continues to bear some of his civilian responsibilities as a son, a husband, a father, or a father-to-be. He still retains some of his narcissistic conceptions and anachronistic fidelities and background, and, perhaps, his childish sense of omnipotence. Small wonder, then, that he should exhibit incipient signs of anxiety that may be focalized about numerous precipitating situations, among which the initial examination is an example! To be a good soldier requires obviously a certain amount of resiliency and adaptability, as well as self-reliance and sufficiency—*i.e.*, adult traits. For some, this readjustment is difficult or impossible to make, and in many cases, we see, during our examinations, the incipient signs of anxieties with regard to such anticipated or impending changes.

Indeed, we often see acutely precipitated anxiety states, hysteria, actual psychoses, panic states, and, in some instances, a paralysing fear and many psychosomatic phenomena such as diarrhea, urticaria, fainting, dysuria, sweating, tremulousness, tachycardia, and hypertension. The question we must decide is, Are these psychosomatic indications enough to warrant rejection? When those who can just manage to get along in civilian life are thrown back upon their own limited capacities for readjustment under new and strange circumstances such as obtain in the army, they are apt to

break down under the stresses, conflicts, and ensuing anxieties that develop, or go AWOL, desert, or exhibit other forms of military misbehavior. Even seasoned soldiers show vasomotor instabilities at sudden changes, such as an order of transfer! What can be expected of the new and untrained and especially the inadequate selectee, worried about the impending upheavals in his life!

These immature, rather preoccupied, socially and occupationally somewhat inadequate and seclusive persons, often with numerous physical defects and stigmata—these dependent, timid adult-children should be considered as rejectable and as unsuitable, even though they are seemingly doing well as civilians protected from disorganizing stresses by close family dependencies. Military life offers little opportunity to depend upon protective devices that are of a seclusive nature and that tend to set one apart. To take such extremely dependent and inadequate persons away from their surroundings without a careful evaluation of such factors as age, degree of dependency, and effect of sudden traumatizing separation, is not good common sense.

The disclosure, during the interview, of a preponderance of such characteristics as a tendency to be shut-in and seclusive with a preference for solitude; fearfulness and insecurity; little interest in competitive sports; frequent temper tantrums; resistiveness to discipline; a history of much truancy from school; an undue dependency upon home and mother; evidences of vasamotor instability such as frequent fainting spells; a history of enuresis, of persistent nail biting, of stammering or ritualistic compulsive traits, should certainly warrant rejection at the induction level.[1]

For others, however, the release from responsibility and the somewhat regulated way of life in the army may prove far from restricting and much less of a strain than a civilian existence loaded with troublesome duties and irritating environmental situations. Sometimes, it may be good therapeusis for the army to effect the severance of the maternally binding "apron strings." As Col. W. C. Porter says, "There

[1] See "What Has Psychiatry Learned During the Present War?" by Col. W. C. Porter, M.C., U.S.A. *American Journal of Psychiatry*, Vol. 99, pp. 850–55, May, 1943.

are many men who would be labeled psychoneurotics at the induction station who would thrive in the military service. It provides the particular conditions and outlets demanded by their personality disorder.'"[1] We must ascertain which types of personality deviation can be utilized in the service, to the advantage both of the army and of the soldier.

In other cases, the army may well be an avenue of "escape" —sometimes rationalized under the false guise of "duty to country," but revealed in an overabundance of anxiety to "get in." The routine, simplicity, relative equality, the group "esprit de corps," the channelized and socially accepted outlet for latent hates, give to some men a certain protectedness, stability, and relief rather than anxiety and dread. For these, the army would be an excellent solution. Indeed, the selectee may exhibit some concern lest he be disqualified—a concern that is, in some cases, well supported and fostered by the acceptable rationalization of self-sacrificing "patriotism," when the real motive, though obscure, is an escape from some emotional difficulty. The question to be decided in such cases is, Will the army be a good solution?

Thus we see that the psychiatric aspect of the selective process is by no means a simple task, but requires a great deal of factual information, expert judgment, and evaluation of the complex personalities of men. We see, too, that it is not strictly or entirely a problem of nosological diagnosis and detection of specific disease syndromes, although any one of the classified disorders would automatically disqualify a selectee. It is more than this process of making a classifiable diagnosis—of merely accepting or rejecting. It is evaluating a personality in terms of fitness for the army, his potentiality as a soldier, irrespective of whether any so-called psychiatrically classifiable disorder obtains—a point of view for which quite a different attitude on the part of the psychiatrist is necessary. There is need to evaluate and to prognosticate—in a sense, to attempt to project the person into his future rôle as a soldier. Objective criteria of personality, which would give the psychiatrist reasonable assurance that the selectee in question would or would not be a

[1] Remarks made at the Military Session of the American Society for Research in Psychosomatic Problems, Detroit, Michigan, May 9, 1943.

satisfactory risk, would be obviously invaluable. But psychological prognosticating is difficult in the present state of our knowledge.

If we, in our examination, however, feel that the selectee in question can withstand, without too much anxiety, a separation from home and family and loved ones, and the continuing psychological and economic responsibilities; if we feel that he is not too dependent upon familiar props, people, and circumstances for comfort; if we feel that he can absorb a loss of individuality without much opportunity to express this in some other way, or can subordinate his personal interests and ambitions and accept the restrictions of discipline, the various necessary deprivations, and at times the increased military responsibilities; if he can withstand sexual deprivation, or has enough flexibility to effect a suitable adjustment or sublimation without too much guilt feeling; if he can take in his stride frustrations and disappointments, lack of promotions, and other super-ego satisfactions; if he is psychologically prepared for warfare and able to overcome the moral scruples and conflicts aroused because of a whole-hearted belief in the justness of our cause; if we feel that he is aggressive, exhibits curiosity and a spirit of adventure, has an interest in his own prestige, is sociable, likes physical sport, and has a fair degree of mature intelligence—then we can feel reasonably certain that he will make a good soldier.[1]

This not the place to review or to discuss the nature of psychoneurotic reactions, but it is well to remember that maladjustment is a complex of personal and situational factors which serve to precipitate anxiety and various defenses against the fears that arise. Such incidents as a disturbing letter from home, cancellation of a desired leave or furlough, inability to obtain a much desired transfer, lack of distraction and relief from long tedious duties, and break in contact with home and family, may be the instigators of much that we commonly call psychoneurotic.

The reactions we observe may represent an unsatisfactory adjustment to the psychological difficulties and situational

[1] See "The Recognition, Prevention, and Treatment of Personality Disorders in Soldiers," by Edward G. Billings. *Army Medical Bulletin*, No. 58, pp. 1–37, October, 1941.

stress that confront the individual, and perhaps the difficulties are a source of more frustation and anxiety than the individual can bear. But these multitudinous conditions cannot be anticipated or ascertained at the induction-station echelon, nor should we try to ascertain them. Every person has a breaking point—some point at which the load of anxiety becomes too much; at which the psychological stress is too great. We may get some indication of a person's adequacy in this respect during an initial examination at the induction station, but to decide, on the basis of the induction examinations alone, the vulnerability, psychologically speaking, of the selectee, and the manifold stresses from which he is liable to suffer, is difficult. In the present state of our knowledge, a trial-and-error procedure must of necessity be followed in many cases, at least at the induction-board level. An inductee who, by actual trial, is vocationally fit for the army, and can perform the duties demanded of him, is a good soldier and should not be labeled as psychoneurotic.

As Colonel W. C. Porter says, all men "will break if their particular breaking point is reached. The conditions attending this war have been such that, in some places, the breaking point of large numbers of fighting men has been passed. No examination given them at the induction station would have predicted that event. The type of warfare, with deprivations of food and water, loss of sleep, constant and incessant bombing and sniping, with no relief, with only hope, and that not realized, and with no comfort except the thought of home . . . that was the fox-hole type of warfare which broke an inordinate number of men. Then, there is the highly mechanized, highly mobile type of action, attended by noise, shell bursts, and dive bombing, that produces mass reactions. Even the best men will show poor battle discipline under such conditions *until they are battle conditioned,* and the men who show it could not have been selected out at induction stations. . . . They are battle reactions, fear reactions, fatigue and exhaustion states. And such reactions should not be stigmatized by the diagnosis of 'psychoneurosis' which carries certain constitutional and personality implications."[1]

How many can withstand the persistent anticipation of

[1] Porter, in "What Has Psychiatry Learned During the Present War?" *loc. cit.*

danger, death, injury, feeling of loss of protection, or forced passivity under stress, without ready means of escape or outlet? Yet who will, and who will not, develop a traumatic neurosis, cannot, in the present state of psychiatric knowledge, be fully and absolutely anticipated, certainly not at the induction station. Furthermore, an important factor, difficult to evaluate, yet sustaining and protective, psychologically speaking, is the general enthusiasm, aggressiveness, conviction that ours is a just and right cause. It creates the necessary drive and assurance—call it "will to win" or "morale" or "esprit de corps"—that makes up for many timidities, fears, uncertainties, doubts, ambivalences, concern for self, which would, in the face of stress, were the morale absent, help to precipitate a breakdown. It is well known "that the incidence of psychosomatic and psychoneurotic symptoms . . . is greatest under conditions, such as retreat before a persistent and ruthless enemy, where food deficiency, loss of sleep, hopelessness and insecurity are present"[1]—in a word, where morale is low.

The development and maintenance of the important factor of morale is beyond the scope of this paper, but it might be of interest in this connection, as Dr. Robert D. Gillespie has pointed out,[2] to remember the part played by useful activity in preventing neurotic manifestations in the R.A.F. Dr. Gillespie also pointed out the contagiousness of fear, and the immunity from it if those around are stolid and unterrified—attitudes largely inculcated by training and experience. Individuals, however, with previous symptoms of anxiety, depression, sensitive and shy persons, are as a rule, unable to withstand the stress of actual warfare, and become foci for "fear contagion," with loss of morale as a result.

While no absolutely reliable criteria can be given, we are warranted in saying that the exhibition of numerous somatic complaints—especially if continued over a long period of time with little relief from medical care—a poor school record, a poor social and occupational adjustment, preoccupation with dereistic notions, or an exhaustive concern with the intricacies of interpersonal relationships, should be sufficient ground for rejection. Seclusiveness, timidity, overconscien-

[1] Porter, *ibid.*

[2] New International Year Book, 1942, Section on Psychiatry.

tiousness, effeminacy, overindependence, great discrepancy between school attainment and type of job, should be evaluated thoroughly before the man is accepted.

Naturally, if the psychiatrist could know exactly where the individual selectee will find himself in the armed forces, what he will be asked to face, he would be in a better position to decide the individual merits of each case. In border-line problems, where a decision is difficult to make, especially where there appears to be a good deal of salvagable personality, and where previous history indicates capabilities that would be useful to the army, it is perhaps wise for the induction-station psychiatrist to give the individual the test of actual service and the benefit of further screening at the reception and replacement training centers, where in any event discharge can be effected should that prove to be necessary.

To summarize, we have attempted to evaluate the psychiatric screening process; to point out some of the methods used and the problems involved; to establish some criteria for acceptance or rejection at the induction-station level; and to point out the difficulties of overzealousness, either in the acceptance or in the rejection of individual border-line or difficult cases.

AN EXPERIENCE IN EXAMINING AN INDIAN TWELFTH-GRADE GROUP WITH THE MULTIPHASIC PERSONALITY INVENTORY

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IN the issue of MENTAL HYGIENE for April, 1941, I reported an experience in testing Indian school children.[1] This experience had left me with the definite impression that the children tested were, as a group, in closer touch with reality, more alive, more aware of all that was going on about them, and less dependent upon material things for happiness than the city children with whom my work brought me into contact.

It seemed to me, too, that the groups from which they came had preserved values that had belonged to our pioneer ancestors, but that are not part of the moral equipment of the present generation of city dwellers. It also seemed to me that I found in their responses courage, dignity, tolerance, humor, and a sense of perspective that would tend to make exaggerated reactions unlikely.

With all this in mind, I felt that the emotional adjustment of Indian groups was a matter worth investigating, and as a first step consulted government statistics as to the frequency of psychosis and suicide in our Indian population. Dr. J. R. McGibony, Director of Health for the U. S. Indian Service, reported that no figures were available as to the frequency of psychosis among Indians, but stated, "It has been our impression that suicide and the various psychoses are less frequent among Indians [than among the white population]. Cerebro-spinal syphilis is an outstanding example by its comparatively infrequent occurrence."

As to suicide, Dr. McGibony supplied a table showing the frequency of suicide among the entire population of the United States and among Indians for a five-year period—

[1] See "An Experience in Testing Indian School Children," by Grace Arthur, MENTAL HYGIENE, Vol. 25, pp. 188-95, April, 1941.

1930 to 1934, inclusive. The rates were calculated per 100,000 of the population. Permission was granted me to quote the following figures:

	Suicide rate per 100,000 of the population	
Year	For the entire population	For the Indian population
1930	15.7	9.4
1931	16.8	5.4
1932	17.4	6.6
1933	15.9	6.6
1934	14.9	8.8

From these figures we are justified in concluding that suicide is not the conventional method of meeting frustration among our Indian population.

Although Landis and Page [1] stated that they found every type of mental disorder reported for Indian groups that are found in our white population, they supplied no data as to relative frequency. But in visiting reservation hospitals, one finds in their records a surprising infrequency of cases of functional psychosis.

Evidently, the impression that exaggerated reactions would not be commonly encountered in the Indian groups had some basis in fact.

The next question, naturally, was in regard to the attitudes, feelings, and opinions of people who could meet great frustration over a long period, as the Indians of the United States have done, without having to take refuge in large numbers either in suicide or in psychosis.

Long personal interviews seemed unlikely to meet with satisfactory response. Questionnaires and paper-and-pencil tests seemed equally unlikely to get the complete response desired. At about this time, the Multiphasic Personality Inventory became available.[2] It consists of more than 500 cards on each of which is printed a single statement. These statements are to be sorted as *True, False,* or *Cannot Say.* If, after reading the statement, "I practically never blush," the individual feels that this is true for him, he files it behind the card marked *True.* If he feels that it is not true for him,

[1] See *Modern Society and Mental Disease,* by Carney Landis and J. D. Page. New York: Farrar and Rinehart, 1938.

[2] See *Minnesota Multiphasic Personality Inventory,* by Starke R. Hathaway and J. Charnley McKinley. Minneapolis: University of Minnesota Press, 1942.

he files it behind the card marked *False*. If he cannot or does not choose to classify it as either true or false for him, he files it behind the card marked *Cannot Say*.

This looked as if it might serve the purpose. So the Multiphasic Personality Inventory and I started back to the Haskell Indian School.

Again, every one was most coöperative. The students were asked not to discuss the test with any one until all had taken it, so that those who took it last could come to it as unprepared as those who took it first. This seemed reasonable to them. They acted upon the suggestion, as the responses showed. The same explanations had to be amplified, the same unusual words defined, the same additional directions in regard to procedure in specific cases had to be given to those who came in on the last day as to those who had come on the first day of the testing. The cards were sorted slowly and thoughtfully. Only a small per cent were relegated to the compartment labeled *Cannot Say* and most of those carried statements in regard to which the students could not have definite information.

One boy classified, "I worry about my wife," and, "My children worry me," under *True*. When questioned, he amplified, "I know I haven't any yet, but I worry about them just the same!" Among Indian groups the home has been a planned project, not an accidental aftermath of a love affair.

The testing ran along smoothly, and the card sorting seemed to be as useful a form of test as it had been hoped it would be—until one afternoon when four girls were working, each with a box of cards. One of them looked up and commented, "Of course, this is all right. We don't mind sorting cards. But it would be so much more interesting to be talking to you about all these things!"

There were 51 girls and 29 boys in the Haskell Indian School group tested. Most of them were doing twelfth-grade school work. Some of the boys who were in their twelfth year of schooling were taking a vocational course instead of the standard twelfth-grade academic subjects. Others were taking a commercial course. Twenty-six different tribes were represented. Nine girls and ten boys were of full Indian blood. Eight girls and one boy were of less than one-half Indian blood.

The age of this group was approximately the same—sixteen years to twenty-five years inclusive—as that of the university group with which their responses are compared. The latter was made up largely of students applying for admission to the University of Minnesota, but it included also some students already in attendance. The university group can be assumed to be slightly older, more advanced academically, and more highly selected educationally than the Indian twelfth-grade high-school group. It included 113 girls and 152 boys.

Dr. Starke Hathaway, one of the authors of the scale, was kind enough not only to lend the material for giving these tests, but to assist in interpreting the results. At the time the test was given, the Multiphasic Personality Inventory was still in process of standardization. The results presented here were obtained with the tentative norms that were available at that time. Both the university group and the Indian high-school group, however, were measured by the scale at the same stage of standardization; so the results may be considered comparable.

As one might expect, these two groups of about the same age, living in the same country at the same time, show many more similarities of thought and feeling than differences. Of the statements classified, between 70 and 75 per cent showed no significant differences between the two groups for either girls or boys.

Differences between the two groups in tendency toward abnormal reaction patterns are shown in the following table. The results for the university group are given in arithmetic means and standard deviations. Because of the relatively small number of cases, those for the Indian high-school group are given in medians and Q. (semi-interquartile range) values. The higher the average, the greater the tendency toward abnormal reaction of the type being measured. For the "Hypochondriac" and "Depressive" values, the farther the score falls below zero, the smaller is the tendency toward abnormal reaction of that specific type. The relatively high Q. values for the Indian boys for hypochondriac and depressive tendencies result from the great distance between the median and the lower quartile values. For "Hypochondriac," the lower quartile is—12; for "Depressive," it is—16.

TENDENCIES TOWARD ABNORMAL REACTION PATTERNS IN UNIVERSITY GROUP AS COMPARED WITH INDIAN

	Constitutional psychopathic		*Hysterical*		*Hypochondriac*		*Depressive*	
	Average	Deviation	Av.	Dev.	Av.	Dev.	Av.	Dev.
University girls.....	22.78	S.* 5.19	18.53	S. 5.64	—2.3	S. 5.52	—3.05	S. 7.996
Indian girls.....	25.00	Q.† 3.25	16.00	Q. 4.00	—6.0	Q. 3.00	—1.00	Q. 4.5
University boys.....	28.53	S. 5.83	17.00	S. 4.89	—2.9	S. 4.50	—4.97	S. 6.994
Indian boys.....	27.00	Q. 3.00	15.00	Q. 2.25	—6.0	Q. 4.50	—4.00	Q. 8.25

* Standard deviation

† Semi-interquartile range.

The authors of the Multiphasic Inventory regard a high score on the "constitutional psychopathic" scale as an index of potential delinquency of the non-neurotic type. It seems possible that disregard of consequences might lead either to delinquency or to heroism. Whatever it signifies, the boys of the university group had the most of it. The Indian boys and girls followed, with the university girls rating the lowest. It may be significant, however, to note at this point that the university girls had the largest percentage classifying as *False* the statement, "It is always a good thing to be frank"!

It had been expected that the Indian students would show marked symptoms of hysteria; repression seemed to demand it. Surprisingly enough, the Indian students showed less tendency toward hysteria than did the white students. Apparently, self-control on a conscious basis is not the same as repression in the psychiatric sense of the word.

The averages indicate that the university students of the groups under comparison were more inclined toward hypochondriasis than were the Indian students. The Indian boys and girls tended to disregard physical discomfort.

The Indian girls showed a little more tendency toward depression than did the white girls. This does not seem unreasonable, since the presence of the white girls in the university indicated that they were able to carry out their plans for advanced training. Many of the Indian girls expressed concern as to what they were going to do the following year, as lack of money made it impossible for them to get the training they wanted.

The boys of both groups showed less tendency toward depression than did the girls. There seemed to be little differ-

ence in this respect between the white boys and the Indian boys, although the white boys came from a favored group with many material advantages, and the Indian boys from an impoverished group with few resources except what they had within themselves.

The responses of the Indian students, both boys and girls, indicated either early disillusion, or early teaching so tolerant and accepting of human frailty that no disillusionment ever was necessary. Can it be that early acceptance of life as it is can insure so tight a hold upon reality that, later, no ordinary life experience can loosen it?

Having done with averages, we can go on to separate items. Only those items were considered that showed 20 per cent or more difference in frequency between the white and the Indian student groups. When it came to these comparisons, it was found that the Indian students were in many ways more like adult white individuals in their ideas than like those of their own age group. According to Dr. Hathaway, the responses of the Indian boys and girls showed greater social and environmental maturity than did those of the university students.

The boys and girls of the university group seemed more sure of themselves, of the rightness of their judgments, and of the interest of the rest of the world in them and in their plans. The Indian students, in significantly higher percentages, wished that they were not so shy. They confessed to being easily embarrassed. The boys felt that they were unusually self-conscious. Boys and girls both admitted that they frequently had to fight against showing that they were bashful. Although their responses indicated a highly sensitive group of individuals, they did not feel that they were more sensitive than most other people.

According to the statements of the two groups, the Indian students were less likely than the white students to express strong approval or disapproval of the actions of others.

The Indian students were very much aware of what went on both inside and outside themselves. It was a surprise to discover the objectivity of their introspection.

As stated before, the responses of the Indian students on many items resembled those of white adults of the ages of

twenty-six to forty-three years, inclusive, more closely than they did those of the white students. The Indian girls and the adult white women were more inclined than the university girls to think that a person should never taste an alcoholic drink. The Indian students, both boys and girls, agreed with the adult white women in hating to have to rush when working.

A larger percentage of Indian girls than of white girls admitted that sex was a source of anxiety. Religious problems seemed to be taken more seriously by the Indian boys and girls than by the university group. One hundred per cent of the Indian students, however, believed definitely that there is a God. Some of the university students were less sure.

The Indian students and the adult white groups were more likely to be sorry for mistakes than were the university students: "I do many things which I regret afterwards. (I regret things more, or more often, than others seem to do.)"

It was a surprise to learn that 68 per cent of the university boys did not like to see women smoke. But 88 per cent of the white adult males and 90 per cent of the Indian boys expressed a similar dislike.

Indian students and white adults more often expressed fear of lightning, infectious disease (tuberculosis is the Indian's archenemy) earthquakes, fire, and wind storms than did the university students, and yet the Indian students felt that they had relatively few fears.

The whole field of acquisitiveness, power, and government, and of ideas in regard to the rearing of children, were left untouched by this inventory. All would undoubtedly have yielded significant material.

In *An Experience in Testing Indian School Children*[1] I reported that the Indian students tested at high-school level made outstandingly high scores on the Point Scale of Performance Tests. This scale demands adequate reaction to unfamiliar concrete situations. Sidney Bijou[2] has since reported for a group under his observation that of two individuals earning the same Binet rating, the one with the high

[1] *Loc. cit.*

[2] See "An Experimental Analysis of Arthur Performance Quotients," by Sidney Bijou. *Journal of Consulting Psychology*, Vol. 6, pp. 247–52, 1942.

rating on the Point Scale of Performance Tests tended to be judged the better adjusted.

The Indian students as a group give evidence of good emotional adjustment. Apparently, they are more highly organized nervously than the university group with which they are compared; they seem to react to more stimuli and to be more aware of what goes on inside and outside themselves than are the white students of about the same age, but with more academic training. The Indian students give evidence of being objective in their observations. They look at themselves and at others fairly critically. They are more like the adult white group than like those of their own age in seeing below the surface and in not taking things at face value. They are not free from worry, nor are they free from fear. But they are afraid of the things that the white adults have learned to fear—lightning, the thought of earthquakes, and other great natural forces that are outside of human control.

Among their attitudes are values that need to be conserved. There are other values possessed by the Indian groups that have not been touched by this inventory. Among them we may be able to find the component factors that together will give us the secret of stability.

The Indian has lost most of his land, but has kept his sanity. We have taken his land, and are using larger and larger tracts of it for hospitals for insane white men and women. Would we be better off, do you think, if we gave back enough of his land to keep him and his children from starvation, and, instead, borrowed enough of his habits of thought to enable the present generation and those to come to retain the sanity that the white race appears to be in grave danger of losing?

MOTIVATIONAL VALUES OF PERIODIC AWARD DAYS AND PLAY FESTIVALS FOR PSYCHOTIC PATIENTS *

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IN the development of more effective rehabilitative programs for the mentally ill, the field of motivational psychology seems to hold promise. It is the purpose of this paper to give a factual account, together with some therapeutic implications, of activities organized and carried out with the aim of retaining and integrating the stimulative interest so necessary to an effective program of reconstruction.

About nineteen years ago, first steps in the organization of a therapeutic recreational program were taken at the U. S. Veterans Administration Facility, Perry Point, Maryland. The patients being comparatively young and of about the same chronological age, it was possible to enlist a large number in such activities as calisthenics, baseball, and volley ball.

From the beginning, it was evident that play has a distinct tendency to enlist the interest of many psychotic patients who apparently are not open to other approaches. Many self-absorbed and distractible types would become attracted to some particular game and, while taking part, would seem able to sublimate unwholesome behavior reactions and to act in a much more normal manner under the excitement of the game.

This situation was studied from the point of view of the therapeutic potentialities that apparently inhere in the game situation, and an attempt was made to organize a more diversified program and to systematize activities more in line with the distinctive mental and physical capacities of the various disease types.

In spite of this classification of activities more closely in

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line with the ability and interest of the patient, however, there seemed to be a very noticeable weakness in the program. While the patients did show much interest in the individual games and in the smokers and other forms of psychological follow-up, it was felt that the therapeutic potentialities of these experiences were not being employed to their fullest extent. The patient's interest would become activated in some game experience, but no definite plans or materials were provided to keep the interest alive, to sustain it, and to attach it to more responsible levels of action. It was fully realized that the physical act of play is not the end of the therapeutic rationale—that the mental experience provides the grounds upon which to build the therapeutic application. The problem, however, of transferring the attitudes of confidence, comradeship, and good will engendered in the game to more responsible situations became more outstanding as the program developed.

Talks with individual patients with various types of mental illness, observation of their play reactions, and consultation with psychiatrists and psychologists, both at Perry Point and elsewhere, increasingly emphasized the importance of planning for long-range objectives in therapy. Many of the patients who had insight stated in effect that they enjoyed the games, but that their pleasure was temporary; that when they had returned to the wards, they still had to contend with their individual problems; and that, while talking about these experiences and going over them in their minds had afforded a certain release from the tension of their difficulties, the effect did not last long enough. This suggestion further emphasized the importance of creating more enduring long-range objectives, so that the patient, when properly trained, might find something that would enable him to focus his attention and sustain it over a longer period of time.

The many grades and types of recreation seemed to constitute a most valuable reservoir of activities for this purpose. Informal discussions with patients indicated that they would be most favorably affected by an opportunity to gain more recognition for commendable progress in their physical-education activities.

In 1928 there was held at Perry Point a public ceremony,

called "Award Day"—"for the purpose of giving suitable recognition to patients who had made meritorious progress in their physical-educational activities." The program consisted of music by a visiting band, introductory remarks by the manager, a talk on the therapeutic values of physical education by the clinical director, the presentation of winners with notations as to their accomplishments by the physical director, and the presentation of medals by the manager. The atmosphere was more that of a college than of a hospital. No special reference was made to illness; humorous anecdotes were interspersed; and one of the patients gave a short talk in which he thanked the officials for the opportunity to show what he could do in the line of athletics.

From that time on, there have been held at Perry Point each year annual Award Day exercises which, in late years, upon the suggestion of the manager, have expanded to include a play festival as well. In addition to the medals awarded for individual accomplishment, certificates of achievement are now presented to members of championship teams. Activities have increased from baseball, volley ball, and calisthenics to a most highly diversified program, including golf, tennis, croquet, table tennis, shuffleboard, pocket billiards, horseshoes, bowling, badminton, swimming, code ball, soft ball, and modifications of these various games to meet the distinctive capacities and needs of the various types of disease and of patient.

Medals are awarded upon the basis of carefully kept records of performance in regular league activities—in duckpins, tenpins, code ball. Elimination contests, in which large groups of patients take part, are held each year to determine the champion in croquet, tennis, table tennis, shuffleboard, and horseshoes. A medal is given to the champion golfer upon the basis of averages in the weekly tournaments. The award for the best all-around baseball player, as well as the best all-around volley-ball player, is determined by the vote of the patient members of these leagues. A medal is also given to the patient who enlists most of his fellows in recreational activities, as well as to others who show the greatest improvement in the various types of activity. In addition to this, certificates signed by the manager and the physical director

are presented to the managers, captains, and members of the various teams that have won championships during the year; also to members of teams, such as the golf team, that have competed successfully with many outside teams, and to the official umpires and scorekeepers among the patients.

These awards are made once a year in a public ceremony attended by leading ex-service officials, psychiatrists, and students of rehabilitation. During the past two years, an average of around two thousand visitors have been present. In addition to the more or less formal ceremony of awards, a play festival is held, in which patient teams compete with teams from outside organizations. During the exercises held on September 7, 1941, fourteen patient teams—including soft ball, golf, volley ball, tenpins, duckpins, tennis, badminton, table tennis, shuffleboard, code ball, pocket billiards, croquet, and horseshoes—played against outside teams made up mostly of men from ex-service organizations. In addition to this, two patient baseball teams played with each other. Patient teams won twelve of the fifteen contests against strong outside teams.

In these exercises, speaking has been cut down to a minimum, the idea being to allow the patients to show what they have been doing as a basis for the honors they have received instead of talking about it. Psychiatrists who have seen these exercises have commented upon the ability of various types of patient, even those regressed, more than to hold their own against strong outside teams. Dr. William R. Dunton, editor of *Occupational Therapy and Rehabilitation*, commented upon the spirit of spontaneity and fun that seemed to permeate the patients, even those who, because of their level of regression, would be ordinarily expected to react in a phlegmatic way.

Therapeutic Implications.—It is evident that the therapeutic rationale behind this innovation presents material for a study of motivational psychology in treatment. Myerson has called attention to the fact that the patient is frequently placed in a vacuum in the hospital environment; having no incentive to develop initiative, he lapses into a "prison stupor." There is no question but that one of the paramount problems of the hospital administrator is to replace

the general passivity of the psychotic patient with a higher level of activity. The general comment on mental hospitals is that there are too many patients sitting around. The reason seems to be that in many cases symptoms rather than causes are treated in the therapeutic program employed. Those who have had long experience in the field of rehabilitation realize that if one is to be successful in promoting therapeutic activities in the psychotic patient, one must vitalize these activities by that subtle element so difficult to discover in the patient's personality—the element of interest. The patient who feels that he is expressing himself in worth-while ways—ways that are not only approved by the public, but recognized and rewarded by the public—finds a deep, sustaining motivation which may stabilize his participation and maintain it. Dr. Adolf Meyer called attention to this fact when he stated that "if we are to help the præcox we cannot coerce him." Progressive psychiatry emphasizes the truth that the growth of the individual in therapeutic practices must come from within rather than from without. The patient can be helped if he can feel that he is doing something worth while.

Furthermore, as Franz has reminded us, the initial act and the end goal of the therapeutic process should not be too far apart. Many therapeutic approaches fail because the individual activity is not related in a vital way to a long-range objective. The patient starts out under the momentum of a game of baseball, for example. If this is organized as an end in itself, he may lose interest; if, on the other hand, the individual game is simply one of a league schedule leading toward the championship, he is much more likely to gain from the experience a sustained and satisfactory mental picture. If, through smokers, discussions, compilations, and the study of records of his performance in the game, the activity is widened to touch other points of social reëducation, he will have gained not only a feeling of personal accomplishment, but also a sense of his social relationships and responsibilities as well as pleasure in living with others.

It is for this purpose that recognition, as organized in such annual Award Day programs as those we have described, has therapeutic significance. The patient who plays golf in the weekly tournaments realizes that he will obtain recogni-

tion for consistent playing. He also realizes that he doesn't have to be the best player to obtain recognition; he may be the poorest, but by showing an improvement from a low score to a consistently better performance, he may win the medal as the golfer who has improved most. The patient who attempts to gain the good will and confidence of others, encouraging them to take part, may be awarded a medal for enlisting the largest number of patients in activity. The patient who shows good sportsmanship in volley ball, who is willing to help the "underdog" and to assist the weaker team, in addition to playing a good game himself, may gain the award of being adjudged the best all-around volley-ball player. The patient who not only plays a skillful game of croquet, but is willing to practice faithfully with another and to develop a well-coördinated type of team play, has a chance to win a medal in croquet doubles. The patient who takes calisthenics faithfully with the ward and attempts to keep his attention on the exercises will have a chance of winning a medal in the final elimination contests. And so all through the recreational program there is a very definite attempt to stimulate the feeling among the patient that worth-while effort not only creates in them a wholesome sense of importance, but also gives them opportunities to secure public recognition of their ability, and that through these activities they are becoming more able to assume again their place and responsibilities in civil life.

The following cases will serve to illustrate the value of recognition in the development of therapeutic motivation:

> Patient X, a manic-depressive, was admitted November 13, 1928. When first interviewed by the physical director about his interest in exercises, he muttered to himself, was seclusive, and while talking rationally, constantly referred to ideas of incapacity and inferiority and stated that he was unable to play any game. He would not participate in games, but would take calisthenic exercises in an automatic and spiritless manner.
>
> Upon being taken to the hand-ball court and after having the hand-ball gloves placed on his hands, he would return the ball after his partner made the first play, at times muttering to himself and at other times expressing clearly his inability ever to play the game satisfactorily. During the hand-ball season, he continued to play daily, although he retained with little change his feelings of inferiority.
>
> He began to play hand ball again the following season and showed improvement in mechanical execution, but continued his complaints of

inferiority, explaining that his whole family were weak and that he could not be expected to do any better; also complaining that he had ruined his life by committing the unpardonable sin of self-abuse. He talked frequently of taking his own life.

He continued to become more active in the game, and the third season showed unusual improvement, winning many of the weekly hand-ball tournaments and finally the medal for the champion hand-ball player of 1931. Write-ups in the weekly paper describing his improvement were read avidly by the patient. He sent copies to his sister and invariably carried these articles on his person. He stated that for the first time he was becoming interested in reading. He made a suggestion to the physical director as to the athletic accomplishments of other patients and suggested that they should receive "a good word." He commented, "You are trying to make a man out of me."

The recognition that he received as champion in hand ball appeared to change his outlook considerably. He became less melancholy and seemed to get some pleasure from the game; he became more social and enlarged the field of his physical activities, playing on the patients' baseball league and the patients' volley-ball league, and in the tennis tournaments.

He received a ninety-day trial visit on October 21, 1931, and was discharged January 28, 1932, because of his very excellent adjustment at home during the visit. Since discharge, the patient has married and is working in a clerical capacity. His home adjustment is most satisfactory. He frequently visits the hospital and seems to be in very good mental and physical condition.

Patient Y, a dementia-præcox case, arriving at Perry Point in 1929, was very psychotic, giving expression to many bizarre ideas and living more or less to himself. He took under his care a flock of ducks and attempted to give them the care that the personnel received, claiming that they were deserving of such treatment. During the first three years, he could not be approached through any recreational means.

In 1932, however, through his contact with an attendant of an infectious personality, he became interested in baseball. The ward was developing a team of championship caliber, and many of the patients were quite enthusiastic about the prospects of this team in the league.

The next year this patient improved sufficiently to play on this team, which won the league championship. The physical director made it a point to praise the patient for his playing, particularly for the improvement that he was making in his social contacts with others. The patient, however, looked upon the game as a strictly competitive experience and could see but little, if any, coöperative value. He stated that he had no sympathy for the losers. He was very much affected, however, by the write-ups in the hospital magazine, which described the progress of his team toward the championship. He stated that such magazines were all right, but that they should "bawl out the losers."

He played regularly on the baseball team, batting an average of 234 for the season. Gaining the recognition of the patients for this, he began to keep track of his daily average and to compile the averages of other members of the league. This was done very carefully and neatly, so that, as he stated, "it would be in good shape for publication."

Gaining confidence from the recognition that he received, he began to play volley ball, studying this game in an analytical manner. His improvement gave him a place on the ward volley-ball team. The same year he gained fourth place in the 100-yard dash in the field-day events on the Fourth of July. He bowled on the ward league bowling tenpin team and became the twelfth best bowler, with an average of 130.5. He kept careful bowling averages of his own performance and suggested that it "might be a good idea to show how a patient improves by putting this in the magazine." This was done, and from time to time in conversation with him the physical director would praise him for his improvement.

He further enlarged his field of activities by taking part in tennis, and became the second ranking player of the hospital. In golf he showed considerable improvement, tying the course record with a 36, and was the fourth ranking player for the year. In code ball he made a record score of 18 for the course. He also became a good calisthenics performer and a fair hand-ball player. In the progression from one type of activity to another it appeared that one of the most stablizing factors was the recognition that he was receiving.

By virtue of his progress in these many lines of physical activity, he became the recipient of the coveted medal as the best all-around athlete at Perry Point. In spite of stiff competition from other patients, he continued to win this medal as the best all-around athlete for seven successive years. During this time a significant change took place in his play attitudes. While in the beginning he had looked upon his play partners as adversaries to be defeated, and humiliated if possible, improvement in his motor skill and the recognition that he received seemed to bring about a more tolerant and social attitude; he began to regard his associates as play partners and to accept some of the ideas associated with the concept of playing with rather than against others. While at first his chief conversation had revolved about his ability to master his opponents, he became more prone to find ability in them and to give them credit for good plays, and, in some cases, he seemed able to acknowledge the values of good sportsmanship.

The game experiences carried out through the years, especially the recognition he received in the form of medals and certificates for championship play and for membership on championship teams, seemed to help in the sublimation of many undesirable traits and to spur him on to further accomplishments. Irrational alibis and delusions were becoming less active through the years.

In 1939 he began to think of going back to work. A graduate of a large university, this patient had many contacts and requested permission from the ward doctor to go out and look for a job. Permission being granted, he soon located a position and returned to the hospital with the request that he be given an official leave to accept. He was granted a ninety-day trial visit, after which time he continued to do well with his work and was discharged. Before leaving the hospital he made the statement that he attributed his improvement to the strong interest that he had been able to find in many types of recreational activity. He is now doing work in a technical capacity, has received promotions, and is happily adjusted.

Patient Z, a dementia-præcox case, admitted in 1923, was so disturbed by noises that he could take but little interest in the activities of the hospital. Quite regressed, at times he would walk on his hands and knees or push himself around with the aid of a large stick. One day, while watching others play croquet, he asked to take part and showed from the very beginning considerable aptitude. He explained to the physical director that he had played croquet as a child and that it was about the only game in which he could find much interest. In his play, however, he was distracted by continuous noises, and would frequently stop the game and swear in a very loud voice.

A notation in the hospital paper stating that he appeared to have skill in croquet seemed to intrigue him. He kept reading this account and made frequent references to it. He continued to play and began to show exceptional skill. In 1929 he won the first championship at Perry Point, and repeated this honor for three successive years. The medals that he received for this accomplishment were cherished by him and he took much pride in sending copies of the annual Award Day program, containing his name as champion, to his friends and relatives.

In 1933 he entered the competition for the state championship in Maryland, sponsored by the Baltimore *News-Post*. Defeating the strongest players in the state, he was proclaimed a state champion and given a large and attractive loving cup suitably inscribed with his name as the champion of Maryland. The Baltimore *News-Post* carried a detailed write-up of this contest, with a large picture of the winner. The patient's feeling of importance was very much inflated by this public recognition, and while talking about these championship games, he seemed but little bothered by the ideas that had caused him so much trouble. He has improved in social contacts and has been given parole.

The difficulty encountered in this case has been to sustain the patient's interest and to find other outlets that would enable him to progress so as to find sufficiently extraverting experiences to sublimate his delusions. It seems evident, however, that the recognition that he received for his accomplishments was one of the most potent motivating factors in his readjustment.

Patient A, a case of epilepsy with psychosis, was extremely timid and fearful of physical activity. In the attempt to induct him into recreational activities, the problem of motivation was prominent. When incited to take part in a volley-ball game, he stated that he was afraid of running into other players. "They might get hurt," he observed. Further discussion with this patient brought out the fact that volley ball is too complex an activity for him.

The next move was to take him to the athletic field where informal horseshoe games were being played. Picking up one of the shoes, he began to play and seemed to have more than ordinary ability in this game.

From time to time thereafter he continued to play in informal contests. The physical director made a special effort to surround these games with a spirit of calm and reassurance, as this patient was easily upset emotionally. The physical director also made a special effort to impress the patient with the fact that these informal contests were good preliminary

practice for the final eliminations which would be held in the fall, at which time the local championship would be determined and the winner would receive a medal emblematic of this high honor.

This therapeutic approach seemed to give the patient an incentive to carry on, and he became more consistent in his participation. He was one of the first contenders in the final eliminations, and in spite of temperamental outbursts he persisted and won the championship. In talking to him afterwards, it seemed evident that but for the long-range objective of the championship contest he would not have continued to play.

In this case the basic emotional instability of this disease entity was taken into consideration, and in addition to the provision of a long-range objective, an atmosphere of calm and reassurance was provided.

Patient B, a case of dementia paralytica, in his first contact with the recreational facilities of the hospital, claimed that he could play any game, and play them all well. He insisted on playing volley ball and baseball, but because of his poor coördination was unable to hold his own with the functional types. In this case the therapeutic problem was not so much that of motivation, as he would try anything; it was rather that of arousing a desire in the patient to take part in activities for which he was mentally and physically suited, such as the simpler types of bowling, billiards, and horseshoes. Therapists had to be careful to see that the patient refrained from engaging in complex activities. When he took part in volley ball, for example, the mental reaction was unfavorable, as it brought into focus his physical inferiority as compared to the præcox cases. In billiards, however, he showed more than ordinary ability, and upon the suggestion of the therapist, played regularly, finally winning the annual championship. The medal that he received for this accomplishment was worn and prominently displayed.

As an example of the value of recognition as a motivating factor, it may be interesting to give a citation of a team championship, read as a part of the ceremony of awarding of certificates to the members at one of the annual Award Day exercises.

WARD 4

"Some one has aptly remarked that all that a patient needs in a hospital is a friend, and the remarkable achievement of the champion Cardinals is due in the main to the fine spirit of coöperation and friendship with which Manager D. has welded these boys together.

"The first half of the league season was won by Manager H.'s Senators, without losing a single contest, while the Cardinals were at the tail end of the league, having lost six and won four games. Then, Manager D. came on the scene and worked most faithfully with these boys, many times playing with them on his day off, and showing a very fine spirit of helpfulness, finally winning the championship for the second half by the close margin of one game. In the play-off series for the championship, the Senators, with their pitching ace George in the box, took the opener 6 to 1. The second game found the Cardinals battling to get

even, trouncing the Senators 16 to 6. The deciding game of the battle was one of the hardest fought contests of the season, the Cardinals with a score of 3 to 2 winning the championship. Over one hundred patients, including those who played in the league and on other ward teams, as well as large groups of spectators, found considerable interest in the game and rooted for their favorites.''

It is believe that publicity in the weekly magazine as well as the discussions of the various members and friends of the teams, and the public recognition that the members receive through the recital of their records and the presentation of certificates of accomplishment, all combine to establish a high degree of therapeutic motivation which has its effect not only in sustaining their performance, but in the development of attitudes of wholesome aggressiveness and comradeship, as well as feelings of the validity and worth-whileness of group unity.

CONCLUSIONS

1. It is our belief that more careful studies in the psychology of motivation will reveal greater areas of usefulness in the field of therapy.

2. Public recognition of accomplishment, in the form of discussions, written accounts, smokers, annual award-day exercises, and play festivals, constitutes a significant therapeutic resource which may be utilized to sustain the patients' participation.

3. Many psychotic patients are unable to coöperate effectively in therapeutic treatment because the immediate task and the end objective are too far separated.

4. Others fail because the motivation becomes an end in itself and is not vitally related to progressive objectives.

5. The psychotic patient desires to show what he can do, and opportunities to demonstrate his ability in a normal situation evoke important attitudes of confidence.

6. In the multiplicity of types and grades of recreational activity, the intelligent therapist may find something that the patient can do and thus organize the initial steps in treatment, which may be upon an automatic level. The problem, however, is to relate this activity to a definite end, so that it may be sustained by interest.

7. Recognition for play activity tends to have a cumulative

effect in developing positive and aggressive traits, enabling the patient to continue in the activity.

8. Giving the patient an opportunity to compete with normals, and training him so that he can compete on favorable terms, has a strong psychological effect in the establishment of a more infectious and vital therapeutic atmosphere.

9. The bases of motivation differ in the organic and the functional types. For the præcox patient, it may be discovered in any part of the motor field that is organically unimpaired. For the patient with encephalitis lethargica, it may be found as a residual of retarded motor accuracy. This type of patient is generally proud of the fact that he can carry out accurate movements in spite of psychomotor retardation—for example, can play a game of billiards and bowl duckpins well.

10. For the dementia-paralytica patient, the attempt to establish motivation, to be therapeutically useful, should emphasize the activities that are within the province of the patient's impaired motor capacity. In other words, the paretic generally cannot be left to his own devices. Because of his defective judgment, he is likely to attempt activities too complex for his level of motivation. Generally, these cases do not need to be motivated to try, but do need the type of motivation that will assist them to sustain their activities in long-range participation.

11. It should be noted that while such therapeutic motivation is an essential element in any successful system of mental reconstruction, it does not necessarily insure the improvement of the patient. Other factors may vitiate its effect in some cases; the depth of the illness, particularly lack of insight in the patient, may make improvement difficult if not impossible. On the other hand, the fact that the patient may not be able to make an extramural adjustment does not do away with the obligation of the hospital to create within its walls all practical media of motivation to assist him to gain satisfactions that will conduce to the highest social intrahospital integration.

12. Finally, such methods of recognition as we have described here not only bring the patient before the public, but bring the public to the patient and promote better understanding and support of hospital administration.

THE MENTAL-HOSPITAL LIBRARY

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THE need for a well-organized library in a mental hospital has been realized only within the last forty-odd years, and the work is still in an experimental stage. In 1904 the first mental-hospital librarian, Miss E. Kathleen Jones, was appointed to the staff of the McLean Hospital, in Waverley, Massachusetts, and the first organized library resulted. Before that there had been miscellaneous collections of books, but here for the first time an intelligent and experienced person guided the collection, and began the work of using books as tools in the cure of mental diseases.

Much of Miss Jones's experience was garnered in her book, *Hospital Libraries,* which has become almost a textbook in this field. In it she elaborated a number of the standards that she had developed in her work, Some of these might be briefly summarized as follows:

The Room.—The library room should be as cheerful, as pleasant, and as non-institutional as possible. In many places the rugs that Miss Jones suggests are out of the question, but it is possible to use paint attractively, and pleasing combinations of colors can be devised. Flowers and color in decorations are always available, and often it is feasible to use paintings by patients. It is very important that the library be in a central and easily accessible place, to encourage its use to the fullest extent. At the Metropolitan Hospital, the fact that the library is so situated has been a deciding factor in its growth and development.

Librarian.—The librarian should have a background of psychiatric knowledge, including familiarity with the more common types of mental disease—how they affect the individual, and so on—and some understanding of the problems that are of most frequent occurrence among mental patients. She should acquaint herself with the individual patients, their educational backgrounds, their hobbies, and their

reading tastes. She should know, also, what kind of therapeutic approach is being made in each case by the doctors and other members of therapeutic departments. It is part of her job to attend staff meetings, to be present at seminars, to go to lectures, and to take every possible means of gaining more knowledge of the work that is being done. She must have an interest in the subject of psychiatry, and in people, and must be ready to spend time and energy in preparing herself to be of value to the hospital. She must have a genuine desire to help the patient. She should have a thorough knowledge of the books in her charge, and imagination enough to see how they can be used in the case of each individual. She should be coöperative in her relations with other departments, and quick to see ways in which the library can bulwark their programs and fit their needs.

The Books.—The building of a library in a mental hospital requires a high degree of skill and knowledge, and an intimate understanding of the specific needs of the institution. The books should be chosen with a well-balanced collection in mind, but they should be selected primarily from a therapeutic point of view. Current fiction often poses a difficult problem, for there is considerable interest in the morbid and unwholesome aspects of life, which are not good for mental patients to dwell upon. In the contemporary world, the treatment of the psychotic patient is often unintelligent, biased, and emotional, and this is reflected in current literature. Travel, biography, history, and other non-fiction subjects are popular in the library and are keenly enjoyed. Current best-sellers are well liked. Through a thorough knowledge of the work being done in the other departments, the librarian is often able to offer supplementary reading material, and to provide books that may help the patient in the attempt to prepare himself for work in the community when he is released.

These criteria were characteristic of the set-up that was established at the Metropolitan when it was opened in 1930. This most modern of the Massachusetts state hospitals was founded with the experience of the others in mind, and a library for the patients was not neglected. Three hundred dollars was set aside for the purchase of books, under the

supervision of the Department of Public Libraries, and Miss Catherine Yerxa, of that department, came to demonstrate the simple mechanics of running the library to the occupational-therapy department, which was to take over its management.

The library was carried on under their supervision for four years; it was handled by one of the patients, and housed in one corner of the basement occupational-therapy shop. Such was its popularity, however, that in 1934 a librarian was appointed to take charge of the collection, and a new location was decided upon, between the female and the male wards on the first floor of the Continued Treatment Building, which houses 1,500 of the 1,900-odd patients. This was a most successful move, and the popularity of the library increased apace. The following figures will show the increase in its use:

	1934	*1941*	
Attendance	5,275	25,373	
Books circulated	3,400	33,285	
Magazines circulated	No record	24,059	
Users	No record	816	(162 employees)

The average daily attendance for 1941 was 110.8. The average number of books circulated was 40; the average number of magazines, 105.

One of the special duties of the librarian in a mental hospital is the recording of notes and observations on patients in various activities, so that the material may be available to the other therapists. A record is kept on individual cards of the daily attendance of patients who come to the library, and a system has been devised by which it is possible to indicate attendance and numbers and kinds of books and magazines used. These data are then transferred to five-year records, so-called, which list them for a period of five years, and show quite dramatically the rise and fall in mental alertness and consequent interest in the library. In the case of special patients, a list of books taken out is kept by title, and this is often very interesting to the doctor in charge. He is often able to pick up in this way clues to the patient's thinking that would not have been open to him otherwise. These records are kept in the patient's folder,

and may be referred to by any one who uses these records.

With the idea that it might be of interest, a study was made of the reading tastes of one hundred and sixty-five patrons of the library, classified according to type of disorder. They were selected from the approximately seven hundred patients who visited the library, on the basis of their apparent ability to gain benefit from reading; those who could not read, or who took out books for effect, were excluded. Eighteen of the one hundred and sixty-five were later excluded also, as representing groups not large enough or not typical enough to be used. The reading tastes of the remaining one hundred and forty-seven may be roughly summarized as follows:

Dementia præcox, simple (11 cases): Variation with education.

Dementia præcox, catatonic (18 cases): Rather spasmodic and poor readers, with a somewhat scattered range of subjects if many books are read.

Dementia præcox, hebephrenic (13 cases): Poor readers. All like novels best by quite a margin. Men showed a preference for Westerns, with a liking for youthful books. One man, however, likes philosophy and psychology.

Dementia præcox, paranoid (44 cases): Likely to be more interested in non-fiction, novels ranking lower with them than, for instance, biography and travel.

Paranoia and paranoid conditions (12 cases): Excellent readers. Show ability to understand and discuss material in books. One woman regularly writes notes on the books that she has read.

Manic-depressive psychosis (16 cases): Good, discriminating readers. Amount of reading dependent on mental condition, with a notable cutting down of attendance during disturbed periods.

Psychosis with syphilo-meningo-encephalitis (7 cases): Like novels.

Psychoneurosis (6 cases): Show a tendency to read for diversion, the women preferring light love material. One man, however, reads current events with great interest.

Mental deficiency (20 cases): Some scattering, with an interest in youthful books, along with a drive to impress with their intelligence and a "show-off" tendency to read good books.

It will be noted that over one-third of the group represented paranoid conditions.

The library's main contribution is to two classes of the hospital population. The first consists of those who are well enough to return to the community eventually, and whose capacity for enjoyment of such comparatively complex pleasures as reading has improved or needs stimulation. To these individuals, the library may be a link between the

hospital and the outside community and may help them to retain old knowledge, or to gain new ideas and information. The daily papers stimulate them to an intelligent interest in the community, and link them up with the world that they have left and to which they will return. They need the best and most careful help at this critical stage, as the transition from institutional to community life is most difficult. The patient in this category presents a real challenge to the librarian as well as to the therapist, and the satisfaction of seeing a patient return to the community with some increase in reading skills, or in the enjoyment of new hobbies, is great.

The second group to whom the library can contribute a great deal is the group of chronic patients whose intellectual endowment is relatively intact and whose reading skills and interests remain alert. Within the hospital environment they are able to make an adjustment that is impossible in the world outside, and their discussion of current events, recent books, and general topics is often most intelligent. Many of the paranoid group are of this type, and some of the manic-depressive group. These individuals derive a great deal of pleasure and satisfaction from library activities, which help them to retain their intellectual faculties and to maintain their morale.

Examples of the various activities carried on by the library will help to illustrate how different activities attract different types of patient.

The Total-push Program.—Since the main characteristic of dementia-præcox patients is a definite withdrawal from reality and a relinquishment of interest in people and in problems outside of their own private all-absorbing ones, they present a challenge, for the dementia-præcox group represents the bulk of the chronic population of the mental hospitals, and they fall victim to increasing deterioration and detachment from reality unless some method is invoked to bring them back. They often sit silent and motionless on a ward, resist every effort to arouse them, and become so deteriorated that they lose interest in keeping themselves neat and tidy.

The total-push program, first outlined by Myerson and

Tillotson, was an attempt to force reality and action on these people, whether they willed it or not. An effort was made to contest their withdrawal by a program that utilized every waking moment. Showers, physical exercises, physiotherapy, occupational therapy, and library were included in their program. In the library an effort was made to stimulate their intellectual faculties. Stories were read and contests devised, such as spelling bees and discussions, and all were encouraged to do some reading, even if it were only to leaf through a picture magazine.

This program was carried out with very deteriorated patients, but they showed relatively little improvement and that merely temporary. The average I.Q. of these patients was 30. Records were kept of the work done with this group. The reason for the work done in the library was the known fact that old school knowledge—spelling, reading, and so on—when recalled, is relatively well retained, and this process was stimulated by the work done in the library.

Special Activities Group.—This group was an outgrowth of the total-push program, in that the same therapists worked with a more advanced group of patients. There were approximately fifteen men and fifteen women in the group, the number varying as the patients left the hospital or failed to respond to treatment. All were chosen on the basis of probable recovery or improvement. As they were more responsive than the total-push group, more interesting work could be done with them.

In contrast to the total-push group, which worked as a group and lived on the same ward, these patients were not segregated or made to feel that they were the objects of special attention. They were met in classes, or in the normal routine of the hospital, and careful records were kept of their progress. Their programs were all different, and special therapeutic projects, such as dramatics, club work, music, and so on, were fitted into their program. Many of them worked, or were transferred to working jobs when they had advanced sufficiently.

Their special problems and needs were studied, and an attempt was made to remedy them. Special therapists were assigned for classes and a conference was held for each service, once every two weeks. Accounts of progress were

talked over, and, if necessary, plans were made or changed in the light of the patient's reactions. In this respect the program followed the total-push program—which, however, worked on programs for the group as a whole, and for persons with a group setting. A special record of reading was kept for all these patients and the titles of the books they read were listed.

The Literary Club.—Many of these patients were organized into a literary club, which was suggested by the psychiatrists working with the group as a means of providing a group setting for those who were interested in literary pursuits. This group was organized on the plan of the literary group of the Worcester State Hospital, although with quite a few individual changes. For the most part, the librarian invited patients to join and chose those whose reading interest prompted the invitation, or who were included in the special group. Patients were also invited to invite their friends, and to suggest those who might be interested. Thirty-eight men and forty women were in attendance at the club, and of this group, eighteen have gone out on visit. On the whole, we have had in the club some of the more active and interested patients, and the departure of a number of them for the community has had a stimulating effect on the rest. The program has been deliberately planned to make the time as active as possible, and only active participants have been encouraged. Each member has contributed to the group, and has had an opportunity to be on the program-planning committees. In parties, each has taken some of the responsibility and has done some of the work. Officers have been chosen by the group, and democratic procedures established.

The program has included the following activities: debating (especially enjoyed by the men); writing (stories, special exercises with words, book reviews, and so on, the *chef-d'oeuvre* being a continued mystery story in five installments, one chapter of which was written by each of five members after a general plot had been decided upon); spelling bees; quizzes of various sorts; charades and games; joint meetings with the music group; reading meetings; play readings; and a number of garden meetings (for work in the library garden). The biggest project was the presentation of two one-act plays which were given on the first anniversary of the club's

inception. Since then there has been quite a bit of emphasis in the group on contributing material to the *Metrolog,* the hospital paper, and some interesting writing has resulted.

Radio Broadcasting.—In November, 1939, at the suggestion of the music director, a program of "Literary Airwaves" broadcasts was started. It was believed that it would be possible to stimulate more interest in the library by means of library broadcasts of a half-hour duration, held once a week, and broadcast to all the wards in the hospital. Originally, the music was planned and played by the music director, but since the formation of a hospital orchestra, made up of patients, the major part of the music program has been contributed by that group.

At first, a series of quiz programs and spelling bees was tried, to interest a large number of persons in the broadcast, and prizes were given for these contests. After a time, however, it became apparent that only a limited number of patients were consistently benefiting from these prizes, and it was decided to substitute dramatic skits for the quizzes. These scripts, which were borrowed from the Federal Security Agency, U. S. Office of Education, Educational Radio and Transcription Exchange, Washington, contain a good deal of excellent educational and dramatic material. This type of dramatic work is particularly adapted to mental patients, as it is suited to their short periods of concentration and attention, does not require memorization, and is a stimulation to the intelligent patient whose intellectual faculties have degenerated, but whose tastes and interests are still alert and well preserved.

In general, the program consisted of one or more talks prepared by the patients on such subjects as the biographies of persons whose birthdays were on or near the date of broadcast, seasonal and holiday material, science talks (by men if possible), travel talks, poetry, book notes given by the librarian, and usually a fifteen-minute dramatic skit. Music was provided by the orchestra, or by the music director on the organ, or there were featured vocal numbers. Program planning was done once a month by the librarian, the occupational therapist in charge of the orchestra, the music director, and sometimes the patients on the program as regular speakers. A valuable source book was *Anniversaries and Holidays,* by Hazeltine. This particular radio activity

gave the patients an opportunity to do some good reference work, and to cultivate an interest in reading books suggested by the topics discussed or useful to them in working up topics. It is undoubtedly one of the most useful adjuncts to the library work at the Metropolitan State Hospital. To date, three bound volumes have been made of the talks and material given on the program.

Staff Meetings.—The librarian, as well as other members of the departments most concerned with the therapeutic activities of the patients, is present at staff meetings, at which there is a consideration of patients' cases, diagnoses, treatment, and placement. From this the librarian derives a great deal of benefit and value. There is excellent coöperation among staff members, and reports from various departments on the patients' welfare are gladly received. Many patients are referred to the library as possible patrons by the doctors and nurses, and the place of the library in the hospital is recognized by the medical staff. Employees are encouraged to attend special lectures and even the post-graduate seminar in psychiatry—which gives them an excellent background in basic psychiatry.

Library Program.—Three morning sessions and two evening sessions of the library are devoted to women, and four afternoons and one evening to men. Two trips to the medical wards are made—to the tuberculous, the female, and the male medical wards. One afternoon is devoted in part to the weekly broadcast, and one other evening to the literary club. A small garden in front of the library is one of its summer interests, and flowers are distributed to all the medical wards during the garden season. This distribution is most eagerly anticipated by those in the Medical Building. The library also sponsors a flower show which is held once a year in the library and to which all patients with gardens contribute. Last year, the third year of the flower show, there were 163 entries.

The librarian has one female and one male patient assistant, and one "special" to push the book truck. Occupational-therapy students are assigned for two-week periods to the library for training as part of their course at the hospital.

The problems of the librarian in a mental hospital are manifold. The mental condition of the clientele is so vari-

able that books given out in good condition may be returned ripped and torn, either by the borrower or by others on the ward. Books may be inscribed with "important government messages," or may be used to "ward off the devil." On the whole, however, they are treated with the greatest of respect and care, and guarded by book lovers who know that all the best things in life have to be fought for and guarded.

Another difficulty that often arises is that patients try to conceal their identities, refusing to give their names to those who want them merely in order to keep a record of the books they take out; they may insist that certain spurious names are theirs rightfully, and indignantly fail to answer to their own. They are most sensitive to the least breath of criticism, and great tact must be used in dealing with the problems that come up, flurries of anger and disapproval arising on the least provocation. On the whole, however, they present an eternally interesting problem, and a true understanding of the people with whom she works is the most valuable asset of the librarian.

No matter how varied her activities, her fundamental aim remains the same—to use all the assets of the library and its resources to help the mentally ill. At present, there is too little background for any mental-hospital librarian to be dogmatic and stilted. The avenue of experimentation and imaginative use of the library lies wide open; how far it is followed depends on the skill and creativeness of the person involved. Through her unique position in the hospital, moreover, she gains an insight into the normal person in the community that makes the background of the public-library specialist, too, a position of experiment and adventure. She gets a picture of the crazy pattern of the community, with its problems and difficulties, that may not as yet be imagined by the public-library worker. In the small community of the hospital she must marshal all her resources to make even a little headway. She must help the sick person to explore and discover some of the delights that are possible in reading, in hobbies, and even in work. Bitten by some mysterious bug, she scorns the lure of other work. On the pioneer work done by individual hospital librarians rests some of the future progress of psychiatry. To her this is the greatest challenge and the greatest stimulus.

ALTERNATIVES FOR THE PERSECUTED CHILD

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MY daughter, aged ten, comes home from school in tears several days a week," reports a mother. "The other children are so mean to her. To-day four of her classmates cornered her and pushed as much snow down her collar as it would hold."

Paul, too young for school, has yet to experience a really happy play period with his little neighbors. Each time the play seems to end by their hiding from him. They think it is great fun.

Grace is a second-grade youngster to whom recess periods are nightmares. Children will come from behind and pin her arms, or push her, or pursue her when she attempts to retreat.

Jonathan, twelve, must pass through a short stretch of woods each day on his way home from school—a terrifying section of the journey because he can never be sure when Jim Hancock's gang will be lying in ambush for him.

Parents and teachers who are normally confident in dealing with children's problems frequently testify that they feel helpless when confronted with children of this type, children who are chronically persecuted. They tell of trying one form of strategy after another, with the helpless attitude of a lost mountain climber who takes one tack after another in a desperate effort to find his trail.

Charles K. is a good example of a child who was subjected to the entire gamut of home-made schemes without any apparent benefit. After a miserable experience in first and second grade, his problem came to the attention of the principal of his school—a white-haired maiden lady endowed with more than average common sense. She called the offending bullies —typical lusty, likable eight-year-olds—to her office. She asked them if they knew what a hard time Charles was having

in learning how to get along in the world. This was a new angle on Charles to his classmates. They were interested and solicitous.

The principal then discussed with them, on an eight-year-old level, the nature of social adjustment, and how some people need more help than others to achieve it. The discussion was friendly, informal, and sufficiently impersonal so that these little pagans could see the problem in its larger social setting. They spontaneously pledged their coöperation in helping to make life less strenuous for Charles while he was struggling to "grow up."

All went well for a time, but, inevitably, the personnel of the class shifted somewhat from month to month, as did the cliques within the class, and after a while it was discovered that the persecution was continuing in more subtle form. During the next school year, the victim's mother requested permission to talk the matter over with the entire class. This only served to make the situation more difficult. Later on, a more far-sighted plan was engineered by the boy's father, who had Charles invite his tormentors, and a few others, to his home for a party of games, in which the father participated. The immediate results were favorable, but again only temporary.

Throughout all of this period, Charles was advised sympathetically by his parents and teachers in clichés such as, "Don't pay any attention to your rude classmates," and, "Act as if you don't mind." Charles tried, but needless to say, these verbal exhortations were of little help. At the close of his elementary-school years, he continued to be easily picked on by his peers, so his father determined upon taking the bull by the horns. He came to the conclusion that Charles was a sissy and that what he needed was the hardening process provided by a military school. "This will make a man of him," he assured himself.

To his grief and dismay, however, the close of the school year brought a report which included the remark, "Charles does not seem able to hold his own with his fellows," and the father found during the ensuing summer months that the boy had become alarmingly withdrawn.

Now Charles may have been an extreme case, and perhaps

nothing short of psychiatric treatment would have helped. It might be argued that in the *average* case of persecution, a bit of verbal encouragement, clever handling of his adversaries by adults, or a military régime would be quite adequate. In isolated cases, where the persecution is mild or obviously linked to a single aggressive pervert, or to some other clearly identifiable factor, it may very well be that any one of these or other stratagems would perform the miracle. It is a common error, however, to gloss over difficulties by selecting too simple a remedy.

There are, on the other hand, those who are too ready to pronounce a child paranoic. A smattering of information about psychotherapy induces an untold number of parents and teachers to look for profound maladjustment, phallic symbols, or complexes where none exist. While no responsible person recommends that a parent or teacher treat a psychotic child, neither does he overindulge in headshaking and sounding the alarm of trouble. The common or garden variety of persecuted child is often able to shake off his difficulty after successful exploration in search of a *technique* for handling his persecutors.

I am convinced, on the basis of work with these targets for teasing and bullying, that they can greatly improve their position through consciously experimenting with attitudes and skills, to the end of eventually acquiring effective ones—just as children can improve their swimming or reading or dancing through conscious efforts to apply knowledge of a new method of thinking and working. "Where there's a skill, there's a way—to overcome fear," concludes Arthur T. Jersild, as a result of extensive research. This applies to the present problem too, because persecution is basically the product of fear.

The persecuted child frequently appears timid toward the world in general. His development may have been unsymmetrical. He may have been overly busy, during his earlier years, building up his inner self, neglecting to strengthen his relations with people. Fortunately, he may contain great resources of inner strength still hidden which will affect and improve his relations with the outer world when he matures, in which case persecution will then cease. As an adolescent,

he may be known and respected as "quiet and competent." His timidity will probably still be with him, but he will have learned, through a rather painful childhood, what he must do to control it and to prevent it from obstructing passable social intercourse. He will probably persist, however, in being thin-skinned, and may show the scars of his earlier maladjustment in numerous ways and throughout life.

He may also be fearful of violating the adult code of behavior. He may feel like striking out at his persecutors, but this impulse is inhibited. He is unduly afraid of possible adult disapproval of acts of violence. He probably is of the thoughtful, reflective type and thus unable to accept a moral code of decency, restraint, and meekness for Sundays and on sanctimonious occasions, to be violated on other occasions when impulse dictates. Some children can do this blithely, unaware of, or not bothered by the necessity of accepting, a double standard.

How can his attitudes and techniques be improved? First of all, it is well to assure the child that he need not become like his adversaries. In my efforts as a teacher to help children face this problem, whether the child be six or twelve, girl or boy, I have found repeatedly the frustrated feeling that one must either be walked over or walk over others. This reflects how distorted the child's view of the world can become. He needs to believe that he does not have to depend on any miraculous personality change, that he need not radically change his likes and dislikes or many of his personal habits, in order to be freed of this plague. He may face the fact that, Heaven knows, these may need changing, but that he had best postpone thinking about them for the present. He may need to be reassured that he has many fine traits, and that these neither should nor need be thrown overboard. He may need to recognize that the problem consists of discovering what others do that exempts them from persecution. He needs to come to the point where he is ready to consider the possible alternatives.

What are they? There are at least three. First, he may continue in his present ways, letting others ride over him. This, he will readily acknowledge, would be most lamentable, in fact immoral, for evil remains on the throne. Furthermore, from a purely practical standpoint, it obviously does not work.

Second, he can let his chagrin, anger, or resentment express itself through a straightforward attack—a fist fight, a slap, name-calling, hair-pulling, tattling—the nature of which will be determined by his maturity, sex, and physical prowess. It will be a clear indication that the victim is not going to let conditions continue as they are. He means business. But he needs first to overcome his fear that he is committing a sin. This direct method, of course, has its shortcomings, as many a military adventurer has discovered. If the attack is not clever or effective or untiring in its persistence, it will appear absurd and will invite further teasing or exploitation, since some mortals take delight in watching the futile thrashing of an infuriated bull. Or if his counterattack is effective, his opponents may feel that they have moral justification for continuing their tormenting, now in a more serious vein. In any case, however, the technique of striking back is better than that of allowing oneself to be exploited. It may clear the air, giving the persecuted a chance to make a fresh start in life.

Third, he can try to be unemotional toward his adversaries, and apply the technique of analyzing their motives, strengths, and weaknesses. He might even try to discover a basis for liking them. This would not necessarily involve mush or sentiment. It might better be a disinterested kind of attitude which simply demands that its practitioner wish no ill to others and wish all to share what good fortune is available. This approach, if used, needs to be planned as carefully as a military adventure would be. It is not so rare. We all have acquaintances, both adults and children, who have this peculiar type of good will and the tendency to dissect others in a thoroughly objective manner. It involves skill as well as attitude, just as fighting or bargaining or flattery are matters both of social skills and of social attitudes. It may be what Buchanan had in mind when he wrote of "sweet indifference."

Children brought up in an atmosphere alive with discussion of personalities and a striving to keep up with the Joneses have but slight chance to develop it. Developed it must be, for it must grow into the fiber of a person and cannot be picked up for occasional adornment. One can learn to be indifferent to the perpetrators of a horror, and yet be stirred

by the horror itself. Those who have personally experimented proclaim that such an attitude is more disarming than cringing on the one hand or expressing righteous indignation on the other; but it is much more difficult to nurture.

The child victim must be left free to try out a number of approaches. The adult's responsibility is to stir him to a point where he will wish to experiment. I once discussed these alternatives with a little girl who had, due to training and native inclination, an aversion to violence. When she recognized, however, that fighting was not ruled out as a possibility, since it was offered in such a way—with the permission of her parents—that it was not associated with sin, she said with evident relief, "That's what I'm going to do—fight!"

This was a good point in her case from which to begin experimentation in learning how to deal more successfully with others. I have no doubt at all that, as she matures, she will find fighting a crude and unrewarding technique. But she required freedom at that point in her life to experiment in social relations without enforced limitations which would unduly narrow her field of action. I have seen children blend the three techniques into unique systems of social intercourse —which were on higher planes of effectiveness than the systems practiced before.

We are not justified in taking the lackadaisical stand that our bullied children will outgrow problems of this type. A mother who reported that she thought her child would outgrow his bed-wetting was told by a psychologist, "Mother, the only thing your child will ever outgrow is his clothing." This is an overstatement, but it is often a necessary attitude. Time and "nature" can work on the destructive as well as on the constructive side. Our children often need our help in analyzing their difficulties, and the art of parenthood, and of teaching, lies in knowing when we are needed for these and other services—and when we are not.

INTEGRATION OF A TRAINING-SCHOOL PROGRAM WITH CASE-WORK SERVICE FOR INDIVIDUAL CHILDREN

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NOT long ago I showed a visitor over the grounds and through the cottages, schoolrooms, chapel buildings, hospital, and clinical and reception units of our training school. He expressed his amazement at finding things so different from what he had been led to expect by what had appeared in the public press and what he had seen in the movies. He was thinking primarily in terms of buildings and the facilities for home life, education, and clinical treatment that he found in those buildings. He did not see or understand the even greater changes that have taken place in the direction of individualizing the treatment of children committed to modern and progressive training schools.

There has been, indeed, a great improvement in the plant and the facilities of training schools in the past thirty years. Beginning with the establishment of the first cottage-type training school for delinquent boys at Lancaster, Ohio, in 1856, there has been a growing tendency toward smaller residence units with increased possibilities of classification. There has also been an increasing recognition of the need for better educational and vocational opportunities within the training schools. But, in the past, training schools, like other institutions and other programs that care for large numbers of individuals, have been limited in the amount of time and attention that could be given to the individual. This limitation still applies to a great many of the training schools—to some more than to others, but to all of them to some extent.

It was only with the development of the profession of social work and, particularly, with the development of mental hygiene and psychiatric concepts that training schools began to develop individualized diagnostic and treatment programs.

Perhaps one of the reasons for this delay is to be found in the fact that the whole philosophy of the care of delinquents was for so long inseparable from that applied to the treatment of adult criminals. The object of the training school was conceived of as punishing the wrongdoer. Even after this philosophy was changed to one of reformation, there was for a long time no real understanding of the need for individualization of treatment. That was still the era of free will, and the importance of psychological and environmental determination of misconduct was not recognized. The general public still believed in punishment as the surest way to reformation. I might add that a great many of the general public still believe that delinquents should be punished. It was to be expected that training schools, which were supported by the public, could not, even if they wished, become too progressive in their treatment of the delinquent.

Training schools mirror, to a certain extent, the philosophy of the times. There was a time when the public believed in locking up the delinquent child in congregate walled and barred institutions. A little later, the public accepted the idea that life on the farm was the panacea for the problem of juvenile delinquency. Then there was a period when military training was looked upon as the answer to the problem and the means of reformation. Still later, when it was found that the delinquents came back from the training schools to the cities from which they had been committed, there was a strong movement in the direction of establishing programs of industrial and trade training in the training schools.

All of these attempts were mass attempts at manipulating the environment for the group. There was no recognition in them of the tremendous complexities of the problem of delinquency. It is true that some individuals were aware of the need for individualized treatment of children in training schools and gave it to them. But, by and large, treatment was thought of in terms of mass handling. Of course, one must remember that up to about 1920 there was no body of information that would have made possible a program of individualized treatment of children, either in training schools or out of them.

Beginning about twenty years ago, there was an accelerated

effort in the direction of studying the individual child and planning a program based upon the information obtained about that child. Some few training schools established mental-hygiene clinics for the purpose of diagnosing the problems and needs of the children committed to their care. Others only employed case-workers on their staff. But there was increasing recognition of the need for an individualized case-work service for the children committed to training schools. It is now generally recognized that a training school without case-work services is incapable of attaining its objective and of performing its function in any satisfactory manner.

There has been a great deal of discussion about institutional care and its attempt to approximate family care in its cottages. We agree with Mayo, Foster, and others that a cottage, housing from fifteen to thirty boys, or girls, is really a form of group care and not a family situation. If we accept this premise, then we should attempt to utilize the developing techniques of group care that are being formulated by the leaders in that field. I think we must recognize the fact that staff members who must supervise fifteen or more children—particularly, the kind of children who come to training schools—are limited in the amount of individualized attention that they can give. We need to supplement their efforts by bringing in members of the staff with social-work training who have enough time and freedom from pressure to enable them to explore the needs of each child. These social workers must secure for us information about the influences that have impinged upon the child, resulting in his delinquent behavior.

Several years ago, we described the place of the case-worker in a training school.[1] We pointed out that, in addition to getting the social history, the case-worker has the responsibility for developing a proper relationship between the family and the school through visits to the home, for the purpose of discussing the progress of and plans for the child. The training school can immunize the child to some extent so that the emotional deprivations of the home and the family

[1] In a paper, entitled *Case-work with Boys in a Training School*, presented at the Sixty-fourth Annual Session of the National Conference of Social Work, Indianapolis, 1937.

will not be so overpowering. But the social worker must prepare the family for the return of the child. His success on placement depends, to a large degree, upon the successful preparation, by the social worker, of the home and the family.

The social worker must break down antagonisms, jealousies, conflicts. He must also organize outside community resources for the better social adjustment of the child. He must know what the child's educational needs are and what facilities are available to meet those needs. He must provide for wholesome recreational and spare-time outlets, if the child's placement is to be successful. He must guide the child to and get him to accept the spare-time outlets. He must help him find a job, if he is old enough to work. After the child's return to his home, the social worker must take over the responsibility for supervising. He becomes the sole connecting link between the child and the institution.

The social worker also has an important function inside the institution while the child is in residence. He brings to the institution information concerning the immunizational needs of the child, so that he may be made able to withstand the detrimental influences of the home or the community. He brings to the supervisors in the school a knowledge of the home conditions about which they should know. He checks up on the child's progress; brings his needs to the attention of the proper persons in the institution; discusses with the child plans for return to home and community.

II

Only one who has tried it can appreciate the difficulty of integrating case-workers and case-work services into a training school. One of the difficulties is that the two groups—the case-workers on one side, the cottage parents, teachers, and supervisors who deal with groups on the other—do not speak the same language. The group supervisors, for the most part, do not have a background that makes it easy for them to understand the mental-hygiene and case-work concepts that the social workers take for granted. The group supervisors, therefore, find themselves on the defensive and may become more than a little resentful.

The case-workers suggest treatment with no knowledge of the conditions under which the treatment is to take place.

They have never tried to supervise a group of from twenty to thirty children and, at the same time, to permit some ego-centered youngster to drain off his aggression at the expense of the group. When the case-worker sees the child in his office, where he is free from group stimulation, the child gives an entirely different impression from the one he gives when he is trying to dominate a group, each component part of which has its own need for sharing the spotlight.

The social worker can be more or less aloof from the consequences of permitting the child to have his own way in a group situation. The group supervisor cannot take refuge in such aloofness. Something must be done about it immediately. The child may be quite reasonable in discussing his overt behavior in the social worker's office, and may listen to an appeal to reason there, but the situation at the moment when he is threatening another child with a stick may not permit of the reasonable appeal. The group supervisor has a responsibility not only for the child with the stick, but also for the child about to be struck with the stick.

We have often wondered whether it might not be helpful to have the group supervisor and the social worker exchange places with each other for a day now and then. Having the administrative responsibility for what might happen has prevented us from undertaking this experiment. Then, too, we have recognized that individual-work skill and group-work skill are quite different. We do find rare individuals who have a capacity for working both with individuals and with groups, but we are convinced that some of our best social workers would be at a total loss if they attempted to supervise a cottage. Some of our group supervisors show more facility in working with individuals than some of our case-workers would show in working with groups.

Sometimes a case-worker finds himself unable to handle the temper tantrum of one child. In a situation where several were involved, we shudder to think what might be the consequences if the case-worker attempted to control the group. The case-worker has learned and depends upon the interview technique. This applies to only a limited extent in group-work situations.

In integrating the work of the group supervisor and that of the case-worker, the first step is to bring about a realization on the part of both that each is performing an essential function directed toward the social adjustment of the child. The case-worker must understand that a lack of individualization in group situations is not merely a matter of lack of competence on the part of the group supervisor, but is also a matter of load. A group supervisor, with the responsibility for supervising twenty-five youngsters, can no more individualize treatment than the case-worker can carry on intensive case-work therapy with a case load of one hundred or more. The group supervisor must insist on a certain conformity to routine, to schedules, and the like. Failure to do so will result in confusion, disorder, and deprivation for a large number of children.

Whenever and wherever groups of people live and work together, there must be adherence to rules and schedules. That accounts for the fact that towns and cities must have local ordinances. It also accounts for the fact that definite schedules, rules, and regulations obtain and must be complied with in military establishments and in institutions. We believe that it is perfectly possible to have rules and regulations that are not petty and that still leave room for individual initiative and choice, but there are a number of matters that need to be regularized. Failure to schedule these increases the difficulty of group living.

In integrating the case-work and the group work of an institution, emphasis must be placed upon the fact that both groups have the same objective and that is to bring about the adjustment of the child to social living. It is true that each works in a slightly different way from the other to attain this goal. We have already indicated that they must understand each other and each other's problems. If they can do this, then they can begin to support each other in achieving the goal at which they are aiming. The social worker can bring to the group supervisor more intimate and personalized knowledge about the needs of the child. The group worker can bring to the social worker a better understanding of the child's reaction to the group and to various situations that occur within the group. The case-worker can recommend the treatment that the child needs.

The group worker can try out this treatment and report to the case-worker on the results of this effort. Together they can plan a modification of treatment which may be more effective.

In this way an actual knowledge of the child's reaction to treatment and a concrete application of theory, with observation of results, can be achieved. The case-worker can remain the person to whom the child goes, sure of an uncritical approach to his problems—and we believe that the child needs some one like that.

The important thing all the way through is that the child's needs be kept in mind by both the case-worker and the group supervisor. Just what is done for or with the child is less important than the attitude toward the child. Rejection is the unforgivable sin so far as a child is concerned. The case-worker and the group worker may make a great many mistakes, their techniques may be bad, but if they convince the child that their attitude is not one of rejection, but rather one of acceptance in spite of his objectionable behavior, they can continue to work with him.

After the social worker and the group supervisor have learned to understand each other, and after they have learned to work together for the best interest of the individual child, there will develop a mutual respect for each other's knowledge and skill. A great many of our social workers have learned from our cottage parents how important and how skillful group work can be in bringing about the social adjustment of an individual child. They have recognized that all of the case-work techniques in the world would have been unable to achieve what a skillful manipulation of group relationships under the supervision of a skillful cottage master has achieved. The group supervisors have learned from the case-worker the importance of understanding the background influences, the previous history, and the emotional reactions of the child assigned to them. They have learned from the case-worker that the most obvious approach to a certain child was the least desirable approach in terms of effective results. In this way, we obtain an integration of case-work services into the training-school program. In this way, we mobilize case-work and group-work therapy to meet the needs of the individual child.

III

We all share to some extent the desire to plan for the future. Just now, on every hand, we hear of plans for a post-war world. I suppose that those of us who are responsible for a training-school program should do our bit toward planning for the future. In a way, it gives us some relief from the trying times through which we are passing. It gives us a lift to picture in our imagination something that is much more ideal than the present situation, with its staff shortages, its food shortages, its equipment shortages, and its many trying problems.

Some years ago, I tried my hand at visualizing the future educational program of the training school. I am keeping that paper as a check on my prophetic abilities. The time that has elapsed since that prophesy was made has been so short that it cannot be disproved. This gives me courage to venture again on the thin ice of prophesy in reference to an integrated case-work-training-school program.

Gradually more and more people are beginning to accept the idea that children committed to training schools need an intensive and individualized type of treatment. More and more people recognize that this treatment, to be effective, must include a higher proportion of professionally trained experts in the field of behavior problems. The training school of the future will include case-workers to work with families and to mobilize community resources to a much greater extent than is now possible. The case load of these case-workers will be reduced to a point where really effective case-work services can be given to the families. The training school of the future will have enough case-workers so that each will carry a maximum case load of from thirty to forty children.

In addition to those case-workers who devote most of their time to work with the families and with the community, the training school of the future will have a staff of case-workers who will devote all of their time to case-work within the institution itself. Their function will be to study carefully each child in the training-school situation. These case-workers will be in constant touch with the cottage parents, the teachers, the work supervisors, the recreational department, and all

others who have responsibility for group supervision. They will also work with the child himself or herself. They will collect information from these various sources for the records and for consideration by case-conference committees. They will do what each superintendent, each teacher, each cottage master, and each group supervisor would like to do in the way of learning how the child really feels about things. They will seek to learn and make available for other members of the staff what his hidden desires and needs are, how much insight he is gaining and how much progress he is making toward a better social adjustment.

The training school of the future will have psychiatrists and psychologists to advise, guide, and direct these case-workers. The psychiatrists and psychologists will help to evaluate the more deeply hidden assets and liabilities of the child. We believe that the training school of the future will be provided with a sufficient number of these professional persons to impregnate the training school with an appreciation of the need for individualized training.

The training school of the future will recognize the vital functions that the cottage parents and group supervisors are required to perform in a training school. It will recognize that cottage parents, in particular, are probably the most influential and the most important group in the training-school program. They will be paid salaries commensurate with their importance. They will be given a professional status that will attract professionally trained group-work supervisors. They will be intellectually, educationally, and emotionally able to work on a mutually self-respecting basis with other members of the professional staff.

In the training school of the future, there will be increasing recognition of the fact that case-work and group work are equally valuable and necessary. The functions and interrelations of each toward the other will be more clearly defined and more generally understood. In the training school of the future, the case-worker, the psychiatrist, the psychologist, the physician, the teacher, the cottage master or house father, the work supervisor, will not assume a competence in a field in which he has not been trained. He will expect to coöperate with, secure information from, and give information to workers in other fields without attempt-

ing to dictate in those fields in which he has no competence. In other words, we will have a group of professionals working together in the training school.

The training school of the future will select staff on the basis of education, training, experience, and personality. Perhaps the greatest emphasis will be upon personality qualifications. These will be determined as we now determine the personality of the child—by means of case histories, and psychological, psychiatric, and medical examinations. We will know more about our staff than we now know about our children. We will give our staff a period of intensive training on the job with tutorial instruction for at least a month before giving them full responsibility.

The training school of the future will provide proper supervision for its staff—a woeful lack at present. We now accept the need for a case supervisor for each five to ten case-workers. Ultimately we should think of a like supervision for group workers in our cottages, our schools, and our shops. These supervisors, working with our case-work supervisors, will bring about the integration of case-work into our training-school programs.

Will all of this cost money? Yes. But the failures of training schools now are costing just as much and the tremendous savings that will result from such a program as we have outlined will be worth what it costs. Think of the distorted and wasted lives that may be reclaimed! It costs money to drain malarial swamps or to prevent the spread of agricultural and live-stock pests, too. Our children are worth more than any of these.

PSYCHIC DETERMINISM IN HOLMES AND FREUD*

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PHYSICIANS whose names are prominent in American psychiatry up to the twentieth century have not been distinguished for notable contributions to the knowledge of mental diseases or even for especially progressive and original thinking. Generally speaking, the outstanding psychiatrists of that period, men like Benjamin Rush (1745–1813), Thomas Kirkbride (1809–1883), and Pliny Earle (1809–1892), were humanitarians, following in the pathways of Pinel and Esquirol and of the Tukes, of York retreat. They endeavored to bring better care, greater consideration and kindness into the treatment of inmates of the mental hospitals, then called asylums, which they directed.

The name of Oliver Wendell Holmes does not appear in books on early American psychiatry. One finds frequent casual references to him as an influential member of the New England groups who rejected the doctrines of predestination and reprobation that thoroughly dominated New England thought and social custom throughout the eighteenth century. This ideology of damnation and predestination, little changed from the days of Luther and Calvin, regarded the mentally ill as inescapably doomed from birth.

Holmes was of course not a psychiatrist, according to the concepts of his time, but we may appropriately inquire what constitutes a psychiatrist as we know his interest to-day. Certainly we cannot limit the term to one whose principal task it is to see that committed patients receive humane care, to classify their mental disorders according to the current preferred nomenclature, and to decide when they can be discharged back into society. More than ever, because of psychoanalysis, which enters so deeply into psychic determinism and the unconscious causality in mental dis-

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orders, psychiatry to-day is interested in cause and effect, in the personal and environmental as well as in the individual and ethnologic aspects of these disorders.

Definitions of psychiatry are not lacking and one of the most recent attempts in this direction is by Dr. Allen Gregg. He states that psychiatrists "study and treat human beings who are inadequate or actually dangerous in their behavior as members of society. . . . The psychiatrist's domain is bafflingly large for it includes derangement of conduct or behavior often discernible only in terms of the patient's relationships with other human beings in some given intellectual or cultural or social or moral system."[1]

A more personal and readily comprehensible definition of psychiatry is that given by a delinquent boy who was told by a social worker that she was going to take him to see a psychiatrist. She asked him if he knew what a psychiatrist was.

"Sure," replied the boy. "He's a guy who makes you squeal on yourself."

Also, we have the flattering definition by the philosopher, William Ernest Hocking—"the psychiatrist is the embodiment of applied science attempting to deal with the ravages of science," or, again, that extraordinary description, if not definition, of the function of the psychiatrist, the psychoanalytic psychiatrist, as sensed by the solitary, curse-ridden soul of the novelist Hawthorne in *The Scarlet Letter*. One hundred years old, it is worth quoting again and again:

> "So Roger Chillingworth—the man of skill, the kind and friendly physician—strove to go deep into his patient's bosom, delving among his principles, prying into his recollections, and probing everything with a cautious touch, like a treasure-seeker in a dark cavern. Few secrets escape an investigator who has opportunity and license to undertake such a quest, and the skill to follow it up."

Then follows a brilliant description of an attitude of passivity on the part of the physician—to-day generally conceded to be the most useful and the safest in psychoanalytic procedure:

> "If the physician possess native sagacity, and a nameless something more—let us call it intuition; if he show no intrusive egotism, nor disagreeably prominent characteristics of his own; if he have the power,

[1] "What Is Psychiatry?" by Allen Gregg. *Bulletin of the Menninger Clinic*, Vol. 5, September, 1942. p. 138.

> which must be born with him, to bring his mind into such affinity with his patient's that this last shall unawares have spoken what he imagines himself only to have thought; if such revelations be received without tumult, and acknowledged not so often by an uttered sympathy as by silence, an inarticulate breath, and here and there a word, to indicate that all is understood; if to these qualifications of a confidant be joined the advantages afforded by his recognized character as a physician—then, at some inevitable moment, will the soul of the sufferer be dissolved, and flow forth in a dark, but transparent stream, bringing all its mysteries into the daylight."

The insight that Hawthorne possessed came from the unconscious, but the determinism for his depressions, his vacillation and estrangement, was ascribed by him to an unavoidable curse which had entered and obsessed his soul like a mysterious spirit from the world of the evil or from the devil himself.

Oliver Wendell Holmes's essays and novels reveal to a great degree the medical and sociologic, the philosophic, and the creative artistic phases of the modern psychiatrist's scope. A glib wit with a rather caustic tongue, Holmes would have chuckled at the mischievous boy's definition of a psychiatrist. He himself once punned of an hysteric that "she had played possum so long that she had convinced herself *non possum*"; that is, she had denied her true urges so long that this denial had become part of her. This is essentially what Freud once said in more formal words—namely, "that the ego strives to attach itself to the neurosis. The further a neurosis progresses, the more suffering becomes an end to itself."[1]

As interpreters of human behavior, Holmes and Freud may at first thought appear to be an odd coupling. Holmes was a typical product of the strict New England heritage of the early nineteenth century, and Freud a man nurtured in the lax and light moral atmosphere of Vienna half a century later. Holmes was an urbane realist, fond of society, alert to current values—something of a politician, they say, while Freud remained throughout his life an isolated investigator and theorist. Yet, as observers and recorders of the psychopathology of the unconscious, and especially in their understanding of the deterministic effect of the sense of guilt on human conduct, these two diversified men of genius arrived at startlingly similar interpretations.

[1] *Hemmung, Symptom und Angst,* by S. Freud. Vienna: Internationaler Psychoanalytischer Verlag, 1926.

Holmes, for all his worldliness, was a philosopher and a physician who sensed the operation of the unconscious which Freud fifty years later, supported by the advances of science in the understanding of mental phenomena, was able to formulate into a theory and a therapeutic method called psychoanalysis. A sceptical medical profession in the twentieth century has accepted reluctantly, in part or in whole, the principles of this theory. Psychiatrists have become familiar, in the vocabulary of Freud, with many of the processes that Holmes described so accurately in his essays and illustrated so vividly in his three psychiatric novels—the latter all written when Holmes was past the age of fifty.[1]

The background of Holmes furnishes some clues to his interest in determinism. Oliver's father, the Reverend Holmes, was a Calvinist minister, though this dour theology did not interfere greatly with his own humane attitude toward life. Nevertheless, Calvinism as a theory, with its fabric forming the woof for a rigid theocratic society, represented an ever-present restriction to the freedom of thought of young Holmes. Before long all his precocious scholarship and his learning were fused into a warm, steady force which tended to melt the hard, frozen concepts of the dispiriting Calvinist doctrine. He did not succumb to the suffering and bitterness into which the repression of the New England conscience drove more sensitive souls, such as Hawthorne. The hardy, hearty Holmes mustered all his intelligence to wage war against it, even as dauntless Sebastian Castellio had dared a similar attack against the fanatical Calvin at Geneva in the middle of the sixteenth century. Castellio risked burning at the stake to uphold the right of man to protest against the despotism of Calvin's cruel dogmas and to defend the right of man to heresy. Holmes faced no such fate, for Calvinist doctrines were going out of fashion among the cultured in Cambridge and Back Bay Boston.

However conservative Holmes may have been in his overvaluation of personal cultural backgrounds and his own social contacts, he lacked neither courage nor power when he proposed liberal ideas. His fight as a radical—for Holmes

[1] For a discussion of these novels, see *The Psychiatric Novels of Oliver Wendell Holmes*, by C. P. Oberndorf, published since this paper was presented by the Columbia University Press, New York City.

was an intellectual radical of his time—lasted from early manhood until his death. From the beginning he hoped to add his skill to the movement to liberate his fellow man from the ravages of preordination and from intolerant modes of thinking and to open pathways for freer expression and living.

No introverting tendencies show themselves in Holmes. If a personal sense of guilt existed in him, Holmes met it with a compensatory urbanity and industry that concealed it well; psychoanalytically, his extraordinary activity and prolific contributions in prose, poetry, and letters may be interpreted as "writing it off." Most likely the fact that the principles of predestination theoretically discouraged the pursuit of scientific medicine and investigation, and by implication would nullify its findings, formed a strong stimulus to Holmes's ardor to oppose and destroy it in all its ramifications.

Science itself supplied him with the necessary weapons with which to fortify his position—namely, that it was not only insulting to God to assert that man be judged as born in sin, but that there was no proof of it—it represented merely a theory. As a theory, it was open to examination and criticism like any other theory, physiological or theological.

When he practiced medicine, Holmes preferred to limit himself to a few cases, carefully investigated and studied over long periods. His medical experiences convinced him that moral obliquities and mental disorders existed for which the individual was no more responsible than for such an antenatal or natal condition as a spastic paralysis. He insisted that in most cases of crime the doctrine of limited responsibility obtained. He pointed out that this limitation becomes almost self-evident from the difficulties which we all experience in determining our own course in situations where we supposedly are at perfect liberty to make a free choice. Often we can do so only after great effort. Still, Holmes maintained that if we are not free, we think we are, and this in itself constitutes a powerful force in compelling us to attempt to shape our lives and destinies. Every person is subject to psychic dualism.

In Holmes's earlier essays in *The Autocrat of the Break-*

fast Table, there are many paragraphs that indicate where his philosophical and psychological thinking and social conscience were likely to lead him—namely, to ridding society "of chattel sin and all its logical consequences."[1] The "logical" consequences which so restricted social custom, warped morality, and blocked learning, Holmes felt must be wiped out. Later, he definitely expressed many conclusions—such as the permanence of infantile memories and experiences, the conflicts arising between different levels of the mind, and the duality of mind—which Freud later explored so thoroughly. A quotation from Holmes's essay, *Mechanism in Thought and Morals,* will illustrate his conviction that early impressions determine and dominate the character of the individual even though no traceable pathology can be shown in the brain.

> "I need not say that no microscope can find the tablet inscribed with the names of early loves, the stains left by tears of sorrow or contrition, the rent where the thunderbolt of passion has fallen, or any legible token that such experiences have formed a part of the life of the mortal, the vacant temple of whose thought it is exploring."

Another quotation deals with the conflict within the personality:

> "But we are all more or less improvisators. We all have a double, who is wiser and better than we are, and who puts thoughts into our heads, and words into our mouths. Do we not all commune with our own hearts upon our beds? Do we not all divide ourselves, and go to buffets on questions of right or wrong, of wisdom or folly? Who or what is it that resolves the stately parliament of the day, with all its forms and conventionalities and pretences, and the great Me presiding, into the committee of the whole, with Conscience in the chair, that holds its solemn session through the watches of the night?"

This passage is reminiscent of the categories of the ego and the super-ego and of dream work which Freud described forty years later.

About fifty years after the birth of Holmes, in a small Moravian village, Freud was born, a member of an alien race. No curse of age-old ancestral sin hovered over him, nor was he oppressed by a harsh, theological doctrine that all the world lay under a divine curse and that the all-pervasive sin into which people were born could be overcome by an experience of regeneration publicly expressed. Still, Freud did regard his race as a factor that ostracized him

[1] In *The Mechanism of the Vital Actions,* by Oliver Wendell Holmes.

socially, especially when he entered the University at Vienna in 1873. From associations he has recorded in connection with his own dreams, it is possible to recognize a much earlier determinant of this feeling. Whatever exclusion he experienced in student days threw him back, not into moody despondency, but into isolation—first of the laboratory and soon thereafter of the quiet of the scholar's study. There he remained, emerging only for brief relaxation throughout his long life.

Those who knew Freud well detected in him the lively imagination of the artist, and his appreciation of the creative arts may have induced him to submit them to notable psychoanalytic interpretations. Joined to this sensitivity for the arts was the orderliness and industry of the scientist—a combination not often met. A man with these exceptional endowments would not be likely to remain long content in the exactitude and precision of anatomical and physiological research which satisfied only one side of his nature. Thus the confidences which the able Viennese general practitioner, Dr. Joseph Breuer, had entrusted to him (in 1882) regarding the importance of repressed early memories in the causation of hysterical conditions, and his own observations of similar problems at Charcot's clinic in Paris, eventually led him into the inexhaustible field of psychological medicine and to a new concept of determinism—psychic determinism.

Psychic determinism, as Freud conceives it, is unconscious and dependent upon memories, incidents, and impressions originating in earliest childhood and usually with a sexual connotation. Freud carried this theory of determinism to the point of asserting that even casual acts, mistakes, and choices in daily life have a definite, if obscure, unconscious psychic causality. He then pointed out that the means of tracing these determinants was at hand—namely, through the interpretation of dream content, the material that the patient puts together while he is unconscious. The method of interpretation is that of free-thought association through which long-encysted thoughts eventually drift to the surface to be reappraised by conscious criteria and conscience. His exploration of this relatively unknown, uncharted domain led to his far-reaching theories and technique, now so widespread that mechanisms like repression and symbolism,

transference and sublimation, well understood and described by Holmes in his psychiatric novels, have become by-words in popular as well as psychiatric literature.

The outstanding and really hopeful feature of Freud's psychic determinism is its personal, plastic, and essentially living nature. Original sin, prenatal guilt, and doom to crime cease to exist as inherited threats from forbidding ancestors. Inescapable theological tenets can no longer discourage us absolutely and imprison our thought. For the sense of guilt is no longer conceived as descending upon us from a vigilant and dominating divinity, but is attributed to cultural processes which have compelled us to regard primitive urges as wicked and have demanded that we repress them.

Many of these instinctual drives are repulsive and disturbing to the individual and to society. Especially offensive to our conscious thought is an unconscious universal infantile sexual inclination of the child to the parent of the opposite sex. The term Œdipus complex has been chosen by Freud to cover this concept. To it Freud has traced the origin of the unconscious sense of guilt. These Œdipal inclinations arise before the child has developed sufficient moral appreciation to regard incest as an offense, either as a sin or as a crime.[1]

Based upon this theory of the beginning of the sense of guilt, Freud proposed an hypothesis "that the conscience of mankind, which now appears as an inherited power in the mind, was originally acquired" from the Œdipus situation. Whether this theory of the origin of guilt be finally tenable or not, the sense of guilt becomes a developmental condition, always present, but variable and dependent for its intensity upon the training of the child, individual and collective. The sense of guilt may thus produce conflict and neurotic compromise, but its existence is also a powerful implement which can be used in the reëstablishment of a norm. In many pathological tendencies, such as homosexuality, alcoholism, compulsion to sexual crimes, and so on, the existence of a sense of guilt is almost necessary for success in therapy and at times, when it still remains uncon-

[1] See *Collected Papers*, by S. Freud. London: Institute of Psychoanalysis, 1924–25. Vol. IV, pp. 342–44.

scious, must be aroused for use in the rehabilitation of the patient.

On the other hand, the primary unconscious sense of guilt sometimes compels people to commit crimes in order that they may submit to and endure punishments in expiation. One finds that criminals sometimes have very little feeling of guilt after a crime because an unconscious sense of guilt has been released.

The sense of guilt, really secondary to an unconscious primary sense of guilt, may be accentuated if the instinctual drives are particularly strong or the repressive forces of a cultural conscience are dominant and severe. The latter would, in effect, correspond to the relentless, the tyrannical God of Holmes's father's church. With all its accessibility and tangibility, Freud's theory of psychic determinism is not wholly mechanistic in spirit. It does not ignore human values and carries with it the moral and social implications of previous forms of theological determinism involving the freedom of the will, against which Holmes protested so effectively. It is significantly different, however, in that it takes this problem away from an irrevocable domination of the past or from an unavoidable damnation in the present and in the future, unless one has been chosen for redemption. Determinism in all its manifestations, physical, psychic, and spiritual—and especially as it affects neurotic and mental diseases—now becomes something amenable to intervention. This represents another and an epochal advance in the warfare of science and predestinate theology; for demoniacal and prenatal determinism not only ceases to exist, but the effects of psychic determinism are opened to change.

The will, to be sure, under such a theory does not become—cannot ever become—completely free through the force of the intellect. Yet through a realignment and readjustment of the coercion, the strength, and the direction of opposing drives, particularly the unconscious ones, relief—frequently even cure—can be brought to the sufferer from the illnesses due to psychically determined and antagonistic wishes. And because the body and the mind are admittedly so closely interdependent, the care and cure of this personal psychic determinism becomes the province and function of the physician, and especially of the psychiatrist.

The philosophy of psychic determinism is individualistic and for this reason would powerfully affect the attitudes to be expected in social customs and criminal law in their estimation of responsibility in individual conduct. In this respect psychic determinism would invite new social and moral approaches comparable to those revolutionary changes which followed the overthrow of the doctrine of preordination in Holmes's time. Among those social reforms of the nineteenth century may be mentioned the abolition of Negro slavery and a more enlightened position in regard to the mentally ill and to legal offenders.

Since I have devoted much time to personal determinism originating in small, but specific experiences, let me refer to a philosopher who ornamented New England scholarship—William James. Although James failed to take advantage of Holmes's observations and failed also to appreciate the vista presented by Freud after he had listened to Freud's Clark University lectures in 1909 at Worcester, the following passage reflects his feeling for the universal and ultimate power of small and individual forces:

> "As for me, my bed is made; I am against bigness and greatness in all their forms, and with the invisible molecular moral forces that work from individual to individual, stealing in through the crannies of the world like so many soft rootlets, and yet rending the hardest monuments of man's pride, if you give them time. The bigger the unit you deal with, the hollower, the more brutal, the more mendacious is the life displayed. So I am against all big . . . successes and big results; and in favor of the eternal forces of truth which always work in the individual and immediately unsuccessful way, underdogs always, till history comes, after they are long dead, and puts them on the top."

It may seem untimely, in these war-time days of mass thinking and thinking for the masses, to venture upon a theme of deterministic individual reactions such as I have presented here. Just now interest in the minutiæ of conduct has given way to mass planning and systematizations and bulk assembly. Thoughts of Nobel Peace Prize winners embrace plans which shall, through legislation, bring liberty and equality to all the peoples of the world rapidly, if not immediately. But the struggles and conflicts of man with his instinctual drives and cultural ideals, developed and set over thousands of years, cannot be changed quickly through laws or plans.

These instinctual drives and their derivatives—pugnacity, hardiness, greed, self-assertion, the challenge to meet the mental forces and the threat of other animal species and to risk life itself in overcoming them—are part and parcel of man's heritage. They always undermine man's rationality and show themselves in unanticipated forms and unexpected moments in the mildest and most deliberate of human beings. For this reason, in a prophetic essay, *The Moral Equivalents of War,* James outlined a plan of civil mobilization of young men for tasks which might absorb and satisfy these instinctual drives without the annihilation of battle.

After all, the individual does make up the mass. No matter how fully the individual may seem to attach himself to mass movements, he yields himself to them only superficially and impermanently. The disheartening aspect of mass attachments, no matter how fleeting, is that they allow primitive impulses, such as lynching or killing in war, to be expressed without direct responsibility on the part of the individual. For this reason there is a strong urge in all individuals to join temporarily with mass groups bent on destruction in which they may indulge forbidden urges with relative impunity. Such mass formations, of course, do not occur only for purposes of violence, but also for the reassurance of power in religious movements such as the crusades and revival meetings.

Yet even military authorities, ever ready to sacrifice the individual for mass benefits through the achievement of wartime goals, know well that the caliber of the individuals composing an army affects its fighting efficiency and also its character and stamina, which constitute morale. Fortunately human nature has a wisdom for the species as the human body has a wisdom for its entire preservation. Each usually stops before it destroys itself. It is, therefore, likely that when long repressed mass sadism, now flagrantly released in wanton warfare practices, reaches its satiation point, society will again revert, in the pattern of Holmes and Freud, to the consideration and respect of the individual's needs as determined by his own experiences.

BOOK REVIEWS*

LIBERAL EDUCATION. By Mark Van Doren. New York: Henry Holt and Company, 1943. 186 p.

This book is by a specialist whose field—the teaching of literature—calls particularly for such broad, humane understanding as Dr. Van Doren wants all college students taught to cultivate. Advocates of Progressive Education will not like it—too much of it runs counter to their philosophy. That it is also so well written may make them regret the more that their own output so often employs the jargon known as "pedaguese."

Though he heartily supports the war, the author sees to-day's scrapping of humanistic studies in favor of military preparations as a further step down a wrong road: "The gravest danger to education now is its own readiness to risk its dignity in a rush to keep up with events, to serve mankind in a low way which will sacrifice respect" (p. 5). Even those who do not think the way out is the one here advocated are familiar with the evils of the elective system—the encouraging of superficiality, the ignoring of tradition, the turning out of "accountants, attorneys, engineers, but not able, earnest, great-hearted men." (Oddly enough this last remark came from Emerson in a day before the system of free choice had been adopted at Harvard.)

Van Doren proposes that all students who attend college shall study, and strictly, the great classics, including those in science no less than in "the humanities." "Liberal education is an education in what all men must know." The process is the mastering, or, at any rate, the acquiring, of the liberal arts. These are so called because they are the liberating arts. The task is "through discipline to acquire the freedom necessary for doing things well."

The author's reasons for wanting this type of education for everybody seems to him self-evident. He holds that man's nature does not change. Human beings differ; but they possess a common nature. Education will bring out the utmost of man's humanity when it takes a high view of this common possession, "the one bond of union in a divided human world." Education is to help the student "become a citizen in the republic of human under-

* For the convenience of readers, The National Committee for Mental Hygiene maintains a book service through which the book reviewed here or any other books on mental hygiene or allied subjects may be ordered.

standing." The task is harder than even many educators appreciate. But this is no reason for permitting education to level down: "American education has been poor, but not because it wanted to be universal, but because it wanted to accomplish so little."

Groups like the Jesuits also made much of education in the classics. But Van Doren is against indoctrination in the sense that teachers are to pass on some body of truth not to be questioned: "It is not how much they believe that matters, it is how well they think; and a democracy which is unwilling that they should think well, no matter what they think, does not trust itself" (p. 37). "The business of philosophy is less with the right answers than with the right questions" (p. 141). "The desire of the true teacher is not to triumph, but to teach, and in teaching to learn" (p. 172). "Authority exists only to be denied by better authority; its best act is to destroy itself" (p. 175).

Here, as elsewhere, for all the author's dissent from Progressive Education, he shows that some of the teachings of this school have influenced him. For instance, there was a time when studies were assumed to discipline to the degree that students hated them, the content of the curriculum mattering little. Van Doren wants the literary classics studied precisely because he regards their content as so important. For the same reason he insists that students learn what has been thought by Archimedes, Galen, Copernicus, Galileo, Newton. Moreover, he wants them to be happy in these pursuits. His statement about elementary schooling—"Reading, writing, and arithmetic are best learned in the setting of art—of use and play."—sounds like Dewey. So does his reminder to older classicists that the study of humane letters has suffered from the snobbish idea that the literary tradition is more to be respected than the scientific.

With regard to elementary schooling, many readers will accord with his indictment (again a common utterance of Progressive Educators) that "while it sends a minority on to better discipline, it leaves the mass of us able to instruct and amuse ourselves only with the cheapest press in history . . . periodicals so depressing in their sameness and so lethal in their poverty of word and thought that we may well question the future of any society which feeds upon them. . . . The population of no age is perfect in taste and judgment. But the common intellect can be debauched, and superstition never did a more vicious job at this than the spurious literature of the news stand is prepared to do. A generation trained in better operations of the reason and the hand, the imagination and the eye, would exist on better pleasures" (p. 97).

Because education even in the classics has often been spoiled

by poor teaching, Van Doren's own plan calls for unusual expertness: "Good teachers have always been and will always be, and there are good teachers now. The necessity henceforth is that fewer of them be accidents. The area of accident is reduced when there is a design which includes the education of teachers. Not the training—a contemporary term that suggests lubricating oil and precision parts, not to say reflexes and responses. The design is less for institutions that turn out teachers than for a whole view of education that sees them as being naturally made when they teach themselves, with the help of one another and their students" (p. 170).

Much in the book, however, calls for dissent. The author is unfair to Progressive Education when he says that it misses being perfect elementary education by ignoring the importance of the human past. In good modern schools the children love to explore the past, and they get abundant chance to do so. Nor do the best progressive schools "ignore the deep resemblances between human beings, calling for a fixed program of learning which no child may evade" (p. 92). Surely the attempt to work out programs that remember both the resemblances and the *differences* merits better appraisal than this. Moreover, though Van Doren says that "most progressive education is libeled when it is accused of refusing to lead," he still repeats the warning that children must not be left to their own devices. When he discusses "formal discipline," he gives little evidence of having read those modern educators and psychologists who studied this particular problem. One of their conclusions he himself repeats when he says (p. 120) that a discipline is transferred from one study to another when the two have certain things in common. (It would be more accurate to say that "discipline is more likely to be transferred.")

He wants society protected "against mass judgments at the eleventh hour," and is confident that this can be assured by the possession of common sentiments that are at the same time sound. This resembles the claim of some one church that only its teachings are both universal and true. It is yet to be proved that men brough up on the classics were for that reason always nobler specimens of the human race. The elective system is comparatively young. By Van Doren's own standard of age-long tradition, is not a sweeping rejection of the system now a bit premature? Besides, when he admits that some kind of vocational training may be necessary, he argues that young men must not be channeled prematurely toward a life that they may discover to be wrong for them: "All men are specialists at last, but there is a time for choice and it is not the time of youth. Youth wants to be all things at once,

and should be given a go at it'' (p. 168). Why does not the argument hold for the freer choosing of other studies as well?

The basic difficulty goes back to Van Doren's assumption that liberal education has to be the same for everybody. ''If the best is known, there is no student whom it will not fit, and each should have all of it.'' This is dogma, hardly in keeping with the title of the book. In the interests of unity, it inclines toward minimizing the diversities. In these days of crisis, it offers a greater threat to democracy than the author realizes. Somebody with time at his disposal might make a study of the education received by the last twenty-five men on the list of the required writings constituting the St. Johns College curriculum which Van Doren so approves. Did Faraday, Mill, Darwin, Marx, James, and Freud get a classical education and recommend it? Incidentally, although the author includes Dewey's *Democracy and Education* in his own selected bibliography, one wonders why St. Johns leaves this book out.

Lest all this seem merely the prejudice of the reviewer himself, let it be added that he is not a disciple of Dewey's, that he took the classical course in college and enjoyed it. Van Doren's curriculum, with the help of gifted teachers, would no doubt liberate some valuable powers that at present do not get the full exercise they crave. To insist, however, that it ''makes inexorable demands which are the same for all'' might well open the door to influences likely to be far from liberal.

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DOSHKOLNOE VOSPITANIE. By F. S. Levin-Shtchirina and D. V. Mendzheritzkaya. Moscow: Utchpedgiz, 1938. 216 p.

This is a guide for teachers and educators of Soviet kindergartens. The author claims it to be the first and the only collection that presents systematized material dealing with pre-school education. It draws its inspiration from the fathers of the Russian Revolution, who insisted on the government's taking an active part in the training of children, and from the Commissariat of Education and its *Guide for Educators of Kindergartens.* The book is divided into nine chapters and deals with such subjects as the objectives of Soviet kindergartens; education in the spirit of communistic morality; methods and means of pre-school education; physical development; play; drawing and molding and occupation with other materials; the development of speech; organization, maintenance, and personnel; and pre-school education in capitalistic countries.

After reading this book one realizes that the Soviet Government

is determined to place its children of between three to seven years of age in kindergartens. In 1936 plans were made to reach almost every child in the country. To what extent this gigantic program has been interrupted by the present war we can only surmise. Preschool education is a government duty. It is supported by local government and the parents of children (25 per cent–35 per cent). In the Russian Republic alone (and there are other republics) over 272 millions of rubles were spent on kindergartens in 1938. To show how this project grew, in 1924 there were in the Soviet Union only 60,200 children in kindergartens; in 1938 the number had increased to four millions. In 1936 plans were made to increase kindergarten stations to 2.4 millions by January, 1939.

The chapter on organization, maintenance, and personnel is very interesting because it goes into extensive detail, not overlooking even the size of tables and chairs suitable for each age. Bookkeeping and budgeting are a part of the program. Manager, teachers, doctor, technical personnel—the qualifications and duties of all are outlined. They are all specially trained. Teachers who cannot handle children or who are emotionally unsuited for the work do not fit into this program. The period between three and seven years of age is very critical. The children must be properly supervised and educated; they must have the best.

Children are placed in groups of not more than twenty-five. They are divided into classes—young (three to four), middle (four to five), and older (five to six). Parents bring the children to the kindergarten singly or in groups at 8 a.m. and take them home at about 4 p.m. The children play, work, paint, mold, draw, take walks, study nature, exercise, wash, sleep, help one another, march, attend theaters—in other words do everything that would bring them in contact with the life around them. Education is planned. Everything in kindergarten has a purpose—play, toys, books, pictures, and so on.

In this mass education every child is at the same time given opportunity to develop its individual aptitude. Every child receives personal attention, his personal problems are studied. Initiative, resourcefulness, self-assertion, curiosity, the choice of his own interests are encouraged and rewarded.

Problems are discussed with parents, and teachers and parents work together. Contentment, interest, example, activity, supervision, variety of play, repetition are the elements of the child's education. The teacher is the example. The emotional relation between teachers and pupils must be excellent. There are no harsh words, no threats, no punishment, nor any suggestion of these in the facial expression or in the emotional reaction of the teachers.

It is a criminal offense in the Soviet Union to punish a child corporally. Punishment of this kind creates fear in the child, makes him inferiority conscious, and may lead to active psychoneurosis or psychosis. The teacher must be positive in his instructions and insist upon the pupils' carrying them out, but commands must be reasonable and understandable and within the limits of the child's ability to fulfill. There are no negative commands—all are positive.

Children are constantly taught such phrases as: "We must play together," "We must share our toys," "We must ask for toys," "We must tell the truth," "We must help the younger children," and so on. Russian children fight and cry and "misbehave" like any other children. Two boys want the same toy; the teacher intervenes, takes the toy, and designates who may have it first, play with it a little, and then give it to the other fellow, if he asks for it. If in the younger group a child is annoying his playmate, he is simply taken away and allowed to play with something else. Taking the child's attention from the object of conflict is another way of solving the problem. In older groups reasoning, explanation, and persuasion are employed.

In some children misbehavior is attributed either to physical health or to improper training at home. These children require special attention, discipline, insistence, and patience from both teachers and parents and their coöperation with each other. Attending kindergarten and mingling with others will lead these children out of trouble. Soviet educators do not encourage special schools or special classes for so-called problem children. I am under the impression that these authors do not recognize major behavior disorders of children in kindergarten, although such disorders must exist in Soviet Union school children and adolescents because they are mentioned in a book on psychiatry by Giliarovsky.[1]

The matter of children's play is given a special chapter. Play, according to Soviet educators, is a means by which a child becomes acquainted with its environment, not something inherited or physiologically predetermined. A child's play is a miniature expression of adult life. Children play everything that they can imitate. All toys are educational toys. Every toy and every play has an objective and is contributory to a child's physical, mental, and social development. The more there is laughter, joy, and humor, the better it is for children at play. Play serves as a means of teaching a child color, form, numbers, letters, and develops his attention, imagination, memory, and so on.

[1] Reviewed by the present reviewer, *American Journal of Psychiatry*, Vol. 99, pp. 629–30, January, 1943.

The development of art in kindergarten is stressed. Stories, verses, and songs are taught and children are made to participate in them. Moving pictures and marionette theaters also are utilized in training.

In the chapter on the physical development of children, physical and hygienic problems are discussed. Good health and a hygienic environment are essential to a child's development. Surroundings must be clean, cheerful, orderly, beautiful, and regular. The régime of kindergarten must never overtax the physical abilities of children. They can do certain things for a certain period of time; they can eat so much and so often; they sleep so long; and they jump from a height of so many centimeters.

Just as the world at large is critical of Soviet pedagogy and the Soviet philosophy of life, so are the Soviets critical of the so-called capitalistic and Fascist theories and practice. The chapter on education in capitalistic countries devotes much space to the inadequacy of their pedagogy. The statement is made that the capitalistic world pays no attention to pre-school education and that the few kindergartens that exist are of a commercial, religious, or charitable nature; they exist in the interest of some class or group. Children, it is said, are divided into classes according to their means, each class having its own program and its own objectives. Frederick Froebel, Mary Montessori, "free education," the American kindergarten, and the pre-school education of Czarist Russia are discussed at length and criticized. Naturally, the book ignores religious education; only one page is given to it.

Of course, one cannot but criticize a few theoretical matters that the authors bring up in their enthusiastic discussion of Soviet pedagogy; it will, however, be left for the reader to do that. As a guide for kindergarten teachers, the book is very good. I recommend it highly for such a purpose.

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THE LITTLE RED SCHOOL HOUSE. By Agnes de Lima. New York: The Macmillan Company, 1942. 355 p.

"Our school is neither child-centered nor society centered," writes Miss de Lima of the school in New York City popularly known as "The Little Red School House." "Rather, we take the child as he is, try to understand him, and then seek to help him understand the kind of world in which he lives and the part he is to play in it."

Miss de Lima and her co-authors' description of the curriculum of each age group of children, from the nursery years through the eighth grade, makes lively and fascinating reading. The story of the origin of the school is told in an early chapter, and the account

of the vicissitudes it encountered is testimony to the strength of purpose and of character that are forever necessary to combat lack of vision, stupidity, and selfish interest.

The kind of education described in this volume (certain of the chapters are written by the teachers themselves) represents not a revamping of traditional courses, but a genuine new way of thinking about the purposes of education, and the creation of an experience for children that *is* "education" in the real sense of that so unhappily misused word.

The children are grouped not according to grade, but according to their chronological ages; consequently there is no school failure or grade repetition. We follow with enthusiasm the doings of the "sixes," the "sevens," the "eights," on up through the "thirteens." Special chapters are devoted to descriptions of the class for children who have difficulty in fitting into the regular groups; the trips that form such an integral part of the school experience of all the children, even the youngest; the camp in the country to which the whole school is moved bodily for one month in the summer; and the use of music, arts and crafts, and the dance in the teaching of children from the pre-school through to the high-school years.

Chapters devoted to the parents of the pupils and to the teachers complete a careful and thorough presentation. Although the day is distant indeed when this splendid educational experience can be shared by all children, a convincing demonstration has been made that it *can* happen here. Chapters on finance indicate that the per capita cost of instruction in *The Little Red School House* is less than that for New York's elementary schools taken as a whole. An appendix includes some original work of the children; bibliographies for children, parents, and teachers; class records; and lists of units of work covered in various subjects by each age group.

I was impressed by the sanity of the education described by Miss de Lima and by its nature, which is at once practical and creative. Teaching content is carefully planned and represents a progression in breadth and depth. The need for discipline, drill, and routine is everywhere stressed. But the discipline, drill, and routine are conceived not as the end and sum total of the "education," but rather as measures to facilitate the *use* of a creative learning experience.

The only reservation I have after reading this really splendid and vigorous account of what in the way of education one wishes for all of America's children, is that children, parents, and teachers in The Little Red School House are for the most part exceptional people, in terms of native endowment, in comparison with the average children, parents, and teachers throughout the length and breadth of this country. Certainly, however, inspiration can be drawn and practical

help gained from a careful reading of this account of one vital experience in education. It will be used in different ways by different groups, according to their convictions, opportunities, and capacities. "School living" within The Little Red School House and its counterparts, were they as plentiful as we so earnestly wish they might be, might well assure us of a coming generation "gay, tough, and curious," as these children have been described—able, perhaps, in some measure, to set right what in this and other countries has so tragically gone wrong.

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CHILDREN'S BEHAVIOR PROBLEMS, VOL. II, RELATIVE IMPORTANCE AND INTERRELATIONS AMONG TRAITS. By Luton Ackerson. Chicago: University of Chicago Press, 1942. 570 p.

The discussion of a problem case at the staff conference of a child-guidance clinic usually stimulates a great many more or less shrewd generalizations. For example, "She is overly interested in boys and often stays out late at night without her parents' knowing her whereabouts; it is a good guess that she is sexually delinquent." "The tendency of this child to worry about his stature and his mother's health suggests that we may be dealing with a personality problem rather than a conduct problem." "His truancy from home and school, his lying and bad companions make it a near certainty that he is also stealing."

Dr. Ackerson's study may be described as an attempt to determine the factual basis for these and ten thousand similar generalizations concerning the interrelations of personality traits and conduct deviations among the problem children seen by child-guidance clinics. His basic data consist of staff notations on 2,113 boys and 1,181 girls examined at the Illinois Institute for Juvenile Research. The analysis is in terms of the intercorrelations of some 125 traits and specific conducts.

The first six chapters are devoted to a discussion of the multitudinous and highly technical difficulties in a study of this type. This introductory discussion is highly recommended to research workers in the social sciences who must collect their data, not under experimentally controlled conditions, but in normal, everyday-living situations. Considering the difficulties involved, the findings are remarkably consistent. They are certainly important. In almost 500 pages of highly concentrated material, the clinician will find literally hundreds of clues and suggestions and hundreds of checks on his powers of

observation, insight, and interpretation. The consistency and wealth of these findings represent a triumph for critical and bold analysis in dealing with what has heretofore proved a decidedly recalcitrant type of datum.

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MENTAL HEALTH IN COLLEGE. By Clements C. Fry, M.D., and Edna G. Rostow. New York: The Commonwealth Fund, 1942. 365 p.

This book is not, as the title might suggest, a general survey of the field of college mental hygiene, but is confined in its scope to a descriptive analysis of the work of the Division of College Psychiatry and Mental Hygiene at Yale University. It is based on the cumulative experience of this unit with 1,257 students who were seen over a ten-year period. As might be anticipated, with but few exceptions the study is concerned with male students only. Abstracts from approximately 150 of the cases are incorporated into the book and constitute its basic framework.

The proportion of the total student population that came to attention during the ten-year period is not given, but of the group studied, the authors point out that 92 per cent were classed as more or less "normal" individuals who encounter difficulties at various times that they cannot solve and to which they react with emotional and physical upsets. Over 60 per cent of these cases were undergraduates and of these almost one-half were freshmen. Fifty-three per cent were seen from one to three times, and the balance were treated intensively over a longer period. Serious psychiatric disorders, such as psychoses, basic personality defects, and severe psychoneuroses, occurred in 8 per cent of the group. The latter are discussed in a separate section of thirty-eight pages which comprises the concluding chapter.

Classified according to the main types of problem presented, the content of this study falls into two parts—problems related to personality growth, and problems concerned specifically with adjustment to the college environment. Personality problems are discussed under the headings of family relationships, sexual behavior and attitudes (39 per cent presented difficulties in this area), and general social adjustment. Problems arising specifically in connection with the university undertaking are discussed in relation to scholastic achievement, student organizations, and special adjustment handicaps peculiar to the undergraduate, graduate, and professional-school levels. Each chapter includes a short explanation and description of student life and activities in Yale's traditional setting and background, and case-history presentations throughout the book alternate

with general comments on the significant mental-health principles and implications for the special age group under consideration.

The fullest appreciation of the value of the work at Yale is gained by reading the authors' case-history abstracts and allowing them to speak for themselves. These give a convincing answer to the question as to how much responsibility a university should assume for the development of students' emotional lives. As the authors repeatedly emphasize, no college can longer ignore the problems related to personality growth and transition if it wishes truly to fulfill its educational goals.

In the preface an interesting historical account is given of the origin and development of the Yale mental-hygiene division, which, incidentally, from the time of its beginning in 1925, was one of the first in America to offer this kind of service to college students. Since this is the first text devoted exclusively to the subject of psychiatry and mental hygiene in college health work, it is regrettable that the authors did not take the opportunity to include a bibliography or to relate their Yale survey directly to the many other general and special studies in the literature. The book will appeal most directly to college faculties and university physicians. It is especially recommended for counselors and parents seeking insight into the handling of mental and emotional problems during the college period.

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WOMEN AFTER COLLEGE. By Robert G. Foster and Pauline Park Wilson. New York: Columbia University Press, 1942. 295 p.

The thesis of this book is that the feminine goal throughout life is marriage, home, and family, while the masculine goal is vocational and economic success. College education is devised primarily for men. Curricula for women in college need revision to help them to better personal adjustments in their life's rôles. To quote the authors, the most important finding of this study is that "both the parents and the educators of our one hundred women, in the elementary school, in the secondary school, and in college, had almost completely ignored the evident need of these women to be prepared for certain inevitabilities of their lives."

The authors base their conclusions on a study of one hundred cases selected from the files of the advisory service for college women conducted by the Merrill Palmer School since 1932, and from voluntary participants enlisted primarily from the college club. The case histories are comprehensive and clearly presented, offering good

examples of the everyday problems of the normal person. If one were to regard this as a statistical study, one would have to be critical of the sampling method, the lack of standardization of the interviews, and the fact that the span of the interviews conducted by six different interviewers was from one to three years.

In their discussion of the failure of the curriculum, the authors base their analysis on an attempt to correlate a transcript of courses and grades with a factoring of the problems of two case histories. Unfortunately they make generalizations as to the value of the educational program on the titles of courses without knowledge of course content.

If one can disregard its obvious errors in methodology as a research study, the book is provocative in that the authors have discussed the continued need for individual diagnosis and guidance from high school through college and after college. The fact that the discussions are based upon the authors' convictions rather than upon evidence does not make them less provocative and helpful to the college instructor or to the social worker interested in guidance and counseling.

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CHILDREN CAN HELP THEMSELVES. By Marion Olive Lerrigo. New York: The Macmillan Company, 1943. 219 p.

A great deal of information has been accumulated in recent years with regard to the growth, development, and activities of infants and children of various ages. It is available to the scientific worker in numerous monographs, schedules, atlases of behavior, and so on. These, however, are too technical to be of great value to the individual parent. Dr. Lerrigo has written an account of child development that can be understood by the lay person. The development of a typical child, called David, is followed over a period of time. Descriptions are given of his degree of physical and psychological development at periods of three months during the first year and of six months during the second year of life. This is followed by yearly accounts up to the age of five, and by two descriptions at intervals of three years each, the tale concluding at the age of eleven. At each year level, such typical activities as eating, sleeping, toilet habits, exercise, play, learning about the world, expressing feelings and emotions, social behavior, and adventuring into the world are considered in some detail.

At all times the needs of the average parent appear to be kept in mind. There is a marked emphasis upon the fact that children

differ from one another in rate of development and that parents must not be alarmed if their child grows more slowly than David in some phases of his life. This same understanding of parental needs is shown in the numerous references to the things about which David's parents become unnecessarily apprehensive.

At times, perhaps, there is an overemphasis on certain phases of development that are easily described, such as the minute details as to how a child throws a ball, but this is only a minor defect in the work.

This book should be of great value to a certain type of parent who wants a real understanding of how a child's behavior develops, and it will serve not only as a complement to the numerous works on the physical care of the baby, but also as a guard against their overemphasis of the average in child development and their minimizing of the importance of human variability. It will help parents to avoid any overanxiety due merely to ignorance or misinformation.

But, of course, no book can be of any real help to that great mass of parents (known so well to our clinics) whose anxiety springs primarily from their own needs and conflicts. No amount of adequate information can aid them or solve their problems. We must not expect Dr. Lerrigo to accomplish the impossible. Where correct information can help, however, she has provided a well-written, readable, and accurate description. It is one that the psychiatrist or pediatrician can place in the hands of his clients, and that should be of real service to them.

GILBERT J. RICH.

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PSYCHOLOGIC CARE DURING INFANCY AND CHILDHOOD. By R. M. and H. Bakwin. New York: D. Appleton-Century Company, 1942. 317 p.

The authors of this book, two well-known pediatricians, have for many years shown a great deal of active interest in promoting among their colleagues an understanding of children's behavior as well as physical health. They have, as Lawrence K. Frank puts it in his foreword to the book, "long recognized that the psychologic vitamins of love and affection and sympathetic understanding are as important as the nutritional vitamins in the wholesome development of childhood and youth."

A fair evaluation of the book must take into consideration the fact that it is addressed to physicians, whom it wishes to "interest and instruct in the promotion of optimal psychologic health in the child." It is, therefore, practical and didactic, some of the chapters being

modified reprints of articles by the authors that had appeared previously in pediatric journals. Controversial issues have been wisely avoided. Those critics who may miss "depth" in the presentation will do well to remember that it is just this emphasis on "depth" that has for a long time deterred pediatricians from feeling that they could make a contribution to the mental hygiene of childhood. Those critics who may find the book a little bit along "textbook" lines should be willing to appreciate the absence of the saccharine sentimentality found in so many popular discussions of the subject.

The thirty-four chapters of the book cover practically everything that the physician is apt to encounter in his everyday pediatric practice. The problems of adolescence are included in the presentation. References to major psychoses or other conditions that are beyond the realm of the non-psychiatric physician are either omitted or mentioned briefly.

This book should be in the library of every physician who has any dealings with children. It is sound, practical, and readable.

LEO KANNER.

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SOCIAL DEFENSES AGAINST CRIME. Edited by Marjorie Bell. (Yearbook of the National Probation Association, 1942.) New York: National Probation Association, 1942. 346 p.

Book reviews must frequently be considered inadequate and unfair to reader, reviewer, and author alike, as they attempt to report and appraise the contents of several hundred pages in little more than as many sentences. This is even truer in the case of a book that is a compilation of contributions from more than a score of authors.

Social Defenses Against Crime is such a book. It is the 1942 Yearbook of the National Probation Association, an organization established to advance probation, parole, juvenile and domestic-relations courts, and community prevention of delinquency, its membership consisting of probation and parole officers all over the country and of other professional persons and lay people who are interested in the objectives of the association.

The book presents a legal digest of legislation and decisions affecting probation, parole, and juvenile courts during 1942, and a review of the activities of the association in that year, but primarily it is composed of papers given at the thirty-sixth annual conference of the association at New Orleans in May, 1942. This "first war-time conference for nearly a quarter of a century," as Charles

L. Chute, executive director of the association, points out in his foreword, was aware of the "danger signs for those at home—in disrupted family life, economic inequalities aggravated by war production prosperity, youth exposed to insecurities and withdrawal of protection"—and "reflected a trend toward closer coöperation of all forces dealing with delinquency and crime."

The most profound and fundamental paper is contributed by Roscoe Pound, Dean Emeritus of Harvard Law School and President of the National Probation Association, on "The Rise of Socialized Criminal Justice." He traces it back to the principle of "public policy" in the Common Law which enabled the judge to refrain from applying even the most fundamental principles of law in a given case if social interests or, to use a contemporary phrase, "a great and overshadowing public policy" forbade it.

The juristic trend from the seventeenth to the end of the nineteenth century was in a different direction. All interests were stated in terms of individual natural rights. Law was considered a restraint on liberty; it was to be held down to the minimum that was necessary to maintain liberty and protect the individual against aggression. The only social interest that was recognized as a controlling factor during that period was the social interest in the general security; this, in nineteenth-century legal thought, meant security of acquisitions and security of transactions.

In contrast with these ideologies, the science of law to-day grows conscious of new social interests in the individual life. Closely connected with this development of legal philosophy is the swing of the pendulum "from an extreme reliance upon systematic administration of justice, according to legal precepts" to an unsystematic administration, with a fairly large amount of discretion in the hands of judges and administrative officials. To-day, in the field of criminal law, socialized justice is functioning through the medium of individualized penal treatment. The juvenile court, the domestic-relations court, probation, parole, the indeterminate sentence, and the coöperation of courts with non-judicial public agencies and with private agencies are milestones in this development.

Margery Fry, former children's court magistrate in London, gives a first-hand report on "Delinquency in War-time England." She admits an increase of juvenile delinqency in England, but warns of the danger of exaggerating cases of temporary indiscipline due to special war-time conditions (evacuation, blackout, lack of schooling and of recreation, absence of parents in the services and war factories) into a general judgment of the moral depravity of English youth. She stresses the fact that "the problem of juvenile delinquency, in war time as in peace, remains one of individual diag-

nosis and individual treatment." She speaks of the new movements, like the "Youth Service Squads" (similar to the Victory Corps in our high schools), which give young people an opportunity to do something worth while for the community during their leisure time. From reports published recently by the British Home Office, we know that the initial increase of war-time juvenile delinquency has been halted, due primarily (it is assumed) to such movements and to the concentrated efforts of the responsible authorities to reëstablish the recreational facilities which had been discontinued immediately after the start of the war.

Surveying the impact of the war on youth in our own country, Arthur E. Fink, Regional Supervisor of the Social Protection Section, Federal Security Agency, Birmingham, Alabama, describes "Youth Problems in War Production and Camp Areas." The number of runaway children has increased in many communities. "Uncounted numbers of young people, chiefly girls and young women," flock to camp areas and industrial boom towns, and often find themselves on the way to prostitution, venereal disease, and jail. Improved protective services on a local basis are needed, says Fink, so that the Federal Social Protection Section can coöperate with local health, welfare, and law-enforcement agencies in carrying through its program of prevention and protection.

The Negro Delinquent, by Professor Walter R. Chivers, of Morehouse College, Atlanta, Georgia, is one of the most thought-provoking papers in this collection. It is not "Negro crime" that he discusses ("for there can be no such crime"), but "crime as it results from the total force of social pressures and disorganization pounding against a group whose connections with the overall mores have been effectively weakened by circumstances over which they have negligible control."

Dr. Chivers speaks of an attitude that he has found among certain juvenile-court officials toward young Negro offenders: "they do not seem to think that Negro youth are biologically capable of reacting favorably to the reform therapy applicable to white youth." His explanation for this and other failures in the handling of Negro delinquents is that many white people erroneously think that they know Negroes. "They know only as much as the Negroes want them to and that is not much," he contends. One of his proposals toward the solution of the problem of Negro delinquency is the assignment of more humane peace officers to Negro-inhabited areas, preferably Negro officers recommended by Negroes and selected by the Negro populace.

To readers of MENTAL HYGIENE, the contribution of Dr. Ralph S. Banay, Chief of the Department of Psychiatry, Sing Sing Prison,

must be of especial interest. In his paper, *Psychiatric Technique and Rehabilitation,* he states that "ten years' statistics at Sing Sing Prison show that ten times as many men develop insanity in prison as in any community throughout the U. S." He reports a special study covering 100 men who were admitted to Sing Sing within a given three-week period; 35 of the 100 had previously been placed on probation and failed. By means of a statistical analysis of these 35 men, including "psychiatric diagnosis and possible cause of failure" and three detailed case histories, Dr. Banay shows that "under closer scrutiny it becomes apparent that those who violated probation could have been predicted as poor risks so long as they remained unaided by prolonged competent psycho-somatic care and treatment."

In the chapter, *The Crime and the Community,* Edward Hayden, Program Director of the Chicago Area Project, describes how the recruitment of all local community forces has substantially reduced crime and delinquency in various low-income areas in Chicago. Lowell Juillard Carr, of the University of Michigan, relates the experiences of the Michigan Child Guidance Institute, which on a state-wide basis provides clinical services for persons under twenty-one years of age and maintains a mobile unit, staffed by a psychologist and two psychiatric social workers, to serve the rural counties.

"The Scope and Place of the Juvenile Court" is discussed by Judge Walter H. Beckham, of Miami, Florida, who proposes "one court for family problems," including both juvenile and domestic-relations courts operating as courts of equity; by Alice Scott Nutt, of the U. S. Children's Bureau, who wants to see the juvenile court limited to purely judicial functions (leaving the administrative and treatment functions to other public and private agencies); and by Peter Geiser, Chief Probation Officer, San Diego, California, who sets forth the opposite view in his paper, *The Court as a Case-Work Agency.* He is joined by Gladys E. Hall, of Tulane University School of Social Work, New Orleans, who, in her article, *Social Case-Work in Probation and Parole,* stresses the point that authority can become a very valuable tool in social case-work in general and in case-work in the official field in particular.

Under the chapter heading, *Services for the Unadjusted Child,* we find a detailed report by Henry Lenz, of the Children's Court, Buffalo, New York, of the successful use of foster homes as places of detention for delinquent children pending court hearing, based on ten years' experience.

Other contributions deal with such topics as pre-sentence investigation, case-work with the adult offender, the youthful problem driver, matching jobs with probationers and parolees, and admin-

istrative problems, such as the consolidation of adult probation and parole on a state-wide basis, and the coördination of probation, institutional, and parole services. In-service training for probation and parole officers is discussed by Richard A. Chappell, Chief of Probation, of the U. S. Courts, and by Charles H. Z. Meyer, U. S. Probation Officer, Chicago, who cover the experiences in this field during recent years as well as the programs planned for the future.

Social Defenses Against Crime, as these short outlines indicate, is full of meat. It proves that theorists and practitioners of probation and related fields are wide awake to the challenging problems of the present and the future.

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JUVENILE DELINQUENTS GROWN UP. By Clifford R. Shaw and Henry D. McKay. Chicago: The University of Chicago Press, 1942. 446 p.

Professor Ernest Burgess, in his introduction to this book, calls it a *magnum opus* in criminology. It is not the sort of book one can blithely review from a hasty reading of the preface, a paraphrase of the jacket "blurb," and the copying of what one hopes is a particularly striking purple passage.

Criminal careers are begun, for the most part, at a disturbingly early age. They are usually well on their way before they are forcibly brought to the attention of those whose business it is to deal with delinquency. As was pointed out in a recent paper in MENTAL HYGIENE, *Social Factors in Delinquency,*[1] the term *first offender* refers only to the first time of being caught *flagrante delicto,* or, for that matter, simply the first time caught. Mr. Shaw and his associates have documented what that paper hinted at—"that the distribution of juvenile delinquents in space and time follows the pattern of the physical structure and social organization of the American city." This belief, common among students of criminal behavior, would now appear to be sufficiently well established in the book under review to remove it from the realm of pious opinion to the certitude of dogma.

What do we have here? Does the book bring us any nearer to understanding the riddle of criminal causation? Are Mr. Shaw and his associates to be enrolled among the social scientists whom Professor Langmuir so justifiably criticized as trying to reduce all human

[1] By George W. Henry and Alfred A. Gross. MENTAL HYGIENE, Vol. 24, pp. 59–78, January, 1940.

behavior to symbols on a chart?[1] This does not necessarily follow. What has been undertaken in the book is the recording of the lives of those whose behavior has been designated as delinquent, and the reader is left to infer that this set of conditions, if repeated a sufficient number of times, may be assumed to be fairly common for delinquents of certain age ranges. What are some of these conditions?

In the older studies, the writers emphasized chiefly the close relationship between conditions of underprivilege and delinquency. The Shaw-McKay study traces out the connection between juvenile delinquency and population movements within the city—a sort of vicious variant of the old economic law that bad money crowds out good. We have business crowding out residential areas; the advent of business into a district sends the economically adequate families further away from the business district; and the houses they vacate are occupied by increasingly underprivileged tenants.

Thus in city after city we see an inner ring of business or industry, surrounded by a district of residences whose occupants are dependent or marginal families. The inner ring is the citadel of the city of crime. There is an intermediate and an outer ring of correspondingly higher-income-level tenants that recruit in lessening degrees youthful delinquents.

On this basis, the authors demonstrate that it is possible for a student to go to a city map, spot the business-industrial area, draw a ring around its outskirts, and say, "Here is your delinquency area." This is in the main true of the cities studied: Chicago, Philadelphia, and Boston in the East; Baltimore, Richmond, and Birmingham in the South; St. Paul-Minneapolis, Omaha, Columbus, and Cleveland in the Middle West; Seattle-Tacoma, Portland, and Vancouver, B. C., in the Far West; together with a group of smaller communities, twenty-one in all.

The book does not profess to be easy reading. The studies of the cities covered, done by experts in their field, require careful interpretation and study, and, as the conclusion suggests, the findings are open to a variety of interpretations. This much, however, is clear—that delinquency is related dynamically to the community. The survey also "appears to establish that all community characteristics, including delinquency, are products of the operations of general processes more or less common to American cities." Thus delinquency becomes an accepted part of the folkways of underprivileged areas. In this connection the authors quote Frank Tannenbaum approvingly: "It is the group that sets the pattern, provides the stimulus, gives

[1] See Irving Langmuir's Presidential Address to the American Association for the Advancement of Science, as reported in the New York *Times*, December 27, 1942.

the rewards in glory and companionship, offers the protection and loyalty, and, most of all, gives the criminal life its ethical content without which it cannot exist."

We have set out for us the causal connection between economic underprivilege and crime. In other words, the low-income group, being furthest removed from the normal social and economic satisfactions, finds it necessary to resort to aggressive methods to relieve its frustrations in this respect. To quote once more: "Crime, in this situation, may be regarded as one of the means employed by people to acquire, or to attempt to acquire, the economic and social values generally idealized in our culture, which persons in other circumstances acquire by conventional means."

The authors approve the suggestion made by us in the 1940 article in MENTAL HYGIENE[1] that crime may seem, on the surface, to pay, and they note that the youngster sees the temporary power and affluence of those who have "made good" in extra-legal and downright criminal ways. They scoff at the notion that crime does not pay. Thus, again, for a large group of the population, the tradition of crime as a means to satisfy certain felt needs must be taken into account.

Fortunately, however, this criminal tradition is not the only dominant factor in the lives of those whose life histories are marked by economic underprivilege. The older and more conventional traditions and behavior patterns, although weakened in their influence, still manage to compete with considerable success against the tradition of criminality.

Do our authors give us an altogether gloomy prospect? And, if the book were to have been written a year later, how much of a change in the picture would be attributable to the psychological upheaval involved in the war? It seems that there are two distinct schools of thought in this respect—one preaching the gospel of an increase of juvenile delinquency because of the war, the other affirming that the war is keeping potential youthful offenders too fully occupied to indulge in criminal activities.

In any case, our authors hold out small hope for individual treatment as a panacea for reducing the frequency of crime. They feel that it is not until we can change the whole social program, and bring the whole force of the community to bear, that we can expect very much. Not until we can see a genuine change for the better in the whole social order can we hope to do much about lessening the incidence of criminal behavior.

Meanwhile, the authors advocate a program of community action

[1] Henry and Gross, *op. cit.*

that is interesting and perhaps workable. The book is thoroughly rewarding, but its appeal will not, alas, be for the general reader or for the amateur criminologist. It is a book for consultation, not a soporific.

ALFRED A. GROSS.

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IN QUEST OF FOSTER PARENTS. By Dorothy Hutchinson. New York: Columbia University Press, 1943. 145 p.

In this short and very readable book, the author discusses the psychological implications of home-finding from the point of view of the social worker and the prospective foster parents. Home-finding is defined as "the selection and evaluation of the foster parents who apply to social agencies or to social workers for children." The author recognizes that during the present world crisis prospective foster parents are not often applicants, but must be sought out. This special problem is dealt with in the chapter, *Home-finding in War Time.* Miss Hutchinson's book deals with the meaning to the prospective foster parents of the experience of seeking a child and being investigated, and accepted or rejected. It deals with the meaning to the social workers of the experience of selecting and evaluating and accepting or rejecting foster parents in terms of their potential usefulness to particular children for whom the agency must be responsible.

The book is written for social workers engaged in home-finding work, but it will, I hope, be read by all case-workers and students who are interested in the dynamics of human relationships as they can be understood through the interview situation. The text is amply illustrated with warm, living case material presented as simple narrative accounts of what the worker saw, heard, understood, and felt about prospective foster parents after initial office interviews and subsequent home visits. Many readers in busy agencies may question, as I did, how feasible it is for all interviews to be as fully recorded as are those that appear in this book. That, however, is an administrative issue with which the author is not here concerned. Her concern is with the process of human evaluation: "The crux of home-finding lies in the selection of normally gratified people."

In the introductory chapter, there is a brief historical review of attitudes toward home-finding. The author shows that the rôle of the home-finder and the techniques of home-finding are con-

ditioned by the current general social philosophy. For example, in describing the early days of home-finding, the author writes: "The unspoken assumption was that foster homes were either good or bad . . . goodness was measured by respectability, morality, and cleanliness. . . . This early era of home-finding coincided with the popular belief that children could be redeemed by an environment unblemished by dirt and distinguished by correct deportment."

This was the period of the "free home" and social workers then felt themselves under an obligation to foster parents and were inhibited by their need to be grateful. As social work began to emerge as a profession, with theories and techniques, workers became self-consciously insistent on meeting the theoretical needs of children. Home-finding entered a new phase. Eager social workers began to demand of foster homes an unreal and conventional perfection. Home-finders, like other social workers, hid their insecurity behind elaborate forms and outlines—the symbols of the new profession. Foster-home investigations became artificial, static portraits of bloodless, unreal people.

As time went on, social workers grew more secure in their rôle. They were able to depart from their stereotyped outlines. The home-finder began to look not for paper-perfect foster parents, but for warm, happy, satisfied persons, whose wish for children was the normal wish to prolong the satisfactions of parenthood, or the normal wish to achieve parenthood which had been physiologically denied them.

It is the responsibility of the home-finder to determine whether prospective foster parents can make a real home for a child and, if so, for which particular child. To meet this responsibility, the home-finder must have a deep, human understanding of the needs that led the prospective foster mother (and it is almost always the wife, not the husband, who makes the original application) to take first the step of applying for a child and then the further step of permitting herself and her home and her family to be investigated.

A chapter, *The Wish for Parenthood,* deals with this important subject of incentives. The author stresses that only when the motivating forces behind the application for a child are recognized and given consideration can the worker fully use the home in the best interests of the child. Most frequently the wish for a child reflects a wish to love or to be loved. What concerns the home-finder is the reasonableness of the prospective foster parents' love specifications. The love specifications of the normally gratified

person are not apt to be unreasonable, whereas the love specifications of the frustrated or ungratified applicant are usually so overwhelming or so inflexible that the child's development as a personality in his own right is impeded.

The special case-work techniques used by the home-finder are described in three chapters dealing with the initial office interview, the home visit, the use of references, and a fourth most important and interesting chapter entitled *Refusing Foster Parents.* Throughout, one feels the author's deep respect for the individuality of each applicant and for the dignity of the professional home-finder. I question whether many agencies throughout the country can afford the time and skill for the foster-home investigations described in this book. Some home-finders may feel that the type of study described is necessary for adoption homes, but impracticable for the many foster homes that must be supplied to agencies, particularly in these times. No case-worker, however, will quarrel with Miss Hutchinson's emphasis on the continued necessity of holding onto and searching for those foster mothers who have a deep capacity for mothering and in whose homes there lie the verities of family life which the foster family is willing and able to share with the child. Love and tolerance in a *home* are stressed as more important than cleanliness and play space in a *house,* though the latter are recognized as also most desirable.

In her final short chapter, *In Praise of Foster Parenthood,* the author gives unstinted recognition to the service rendered by foster mothers. She contrasts the difficulties to be faced in living with and loving and rearing one's own child, and those that must be met in dealing with the child who comes to one full of resentment toward his past which will be projected onto his present, and who has deep loyalities to persons and a way of life remote from that of the foster home. Problems in relation to the child's past, to the child's still living own parents, and to the supervising agency are but a few of the complications that beset the foster mother. "Foster mothers are very human beings and have claims to all the foibles characteristic of people in general. Their greatest value lies in their gift for mothering and in the acceptance of themselves as truly maternal women."

If home-finding in the past has been regarded as a handmaiden of case-work, this book will destroy that concept. Home-finding is an integral part of child placement. It is unfortunate that for administrative reasons in many agencies the functions of the home-finder have been segregated from those of the case-workers

who actually supervise the placement of children. After reading this book, I felt even more strongly than before that finding the home, placing the child, and supervising the placement are all parts of a single piece of case-work. Division of labor is efficient from an administrative point of view, but destructive from the point of view of sustained warm, human relationships.

FLORENCE CLOTHIER.

New England Home for Little Wanderers,
Boston, Massachusetts.

INTRODUCTION TO PSYCHIATRY. By W. Earl Biddle, M.D., and Mildred van Sickel. Philadelphia: W. B. Saunders Company, 1943. 358 p.

This new textbook for teaching psychiatric nursing opens with a clearly presented discussion of the purposes, organization, and point of view of the staff of a well-run mental hospital. The various common types of psychiatric treatment are discussed in considerable detail, with sections on the rôles of occupational and recreational therapy in the total therapeutic armamentarium.

The section on psychiatry is concisely and simply formulated, adhering closely to the American Psychiatric Association's psychiatric classification. Abstracted case records illustrate each syndrome described. Perhaps greater emphasis could have been obtained, however, by describing fewer syndromes. For instance, involutional psychosis might well be included as part of the manic-depressive group, and a group of nurses hardly need to differentiate six types of alcoholic psychosis as here set forth.

The authors fall into the common psychiatric error (which they deplore in a later chapter) of implying more knowledge of the prevention of psychoses than most of us feel we possess. Each section contains a paragraph on prevention, which for this reason is necessarily lame and could better have been omitted. The one group of mental disorders about which we really know something in the line of prevention—*i.e.*, the psychoneuroses—are not very fully discussed here, and the pages devoted to this important aspect of psychiatry do not contain a discussion on prevention.

The final sections of the book deal with legal considerations, mental hygiene, and a very condensed discussion of psychiatric schools of thought. These chapters, although brief, will be helpful to mental-hospital nurses and the social worker affiliated with the mental hospital. This book constitutes a good nursing-school textbook, to be used in conjunction with other material. Its chief defect as a

complete nursing text lies in its state-hospital point of view and its comparative neglect of the psychoneuroses and of psychosomatics. A book that will really interpret psychiatry to psychiatric social workers, in a broader field, and public-health nurses is still to be written.

MARGARET C.-L. GILDEA.

St. Louis, Missouri.

RELAXATION. By Josephine L. Rathbone. New York: Teachers College, Columbia University, 1943. 157 p.

Muscle tension results in fatigue, which is normally followed by periods of rest and then renewed vigor. Under conditions of strain, insecurity, and fear, ever-present in the world to-day, the normal rhythm is neglected and lost and chronic residual tension or "hypertonus" results. People forget to relax and then find that they no longer know how. The author of *Relaxation* offers the book as "a venture in education" and recommends relaxation as an "aid to total fitness." She assumes that an understanding of why and how we become tense, as well as how to relax, is needed by those who are beginning to show symptoms of fatigue, as well as by those who find themselves on the verge of exhaustion and collapse.

The chapters on tension include discussions of the physiological and psychological factors in fatigue. The author not only draws upon her own wide experience in discussing techniques for relaxing, but also describes certain procedures of the system of Yoga for releasing muscle tension and quotes at some length the Jacobson methods of teaching muscles to relax at will. The discussions on psychological techniques suggest in outline Cabot's philosophy of "work, play, love, and worship."

The book is clearly written and terms are nicely defined. The author arouses one's interest in the need for releasing muscle tension and conserving human energy. The directions for the various physical techniques are simple and easy to follow. The book has a certain popular appeal and can serve as a useful and practical guide.

But while it can be highly recommended for its practical advice on physical techniques, in the discussions of the psychology of fatigue and tension, the author is at times unfortunately less objective, and certain sections of the book verge dangerously on sentimentality.

RUTH E. FAIRBANK.

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NOTES AND COMMENTS

Compiled by

MARY VANUXEM, PH.D.

New York State Committee on Mental Hygiene of the State Charities Aid Association

COOPER UNION FORUM HONORS CLIFFORD BEERS

A symposium on the career of Clifford Whittingham Beers and the future of the mental-hygiene movement which he inaugurated was held at the Cooper Union Forum on January 4. The speakers were Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene; Dr. C.-E. A. Winslow,[1] Professor of Public Health at Yale Medical School, who was associated with Mr. Beers in the founding of the National Committee; and Dr. George K. Pratt, author of *Your Mind and You,* and formerly Executive Secretary of the Connecticut Society for Mental Hygiene.

The meeting, which was open to the public, was one of the Cooper Union Forum's series, "Rough Sketches of the Future." Explaining the purpose of the series, Dr. Houston Peterson, head of the Division of Social Philosophy of Cooper Union, who presided at the meeting, said: "Charts, blueprints, and discourses on 'the shape of things to come' so often arouse cynical suspicion, that we are offering instead a number of 'Rough Sketches of the Future' which should be illuminating without being pompously prophetic. The recent death of Mr. Beers is the occasion for a symposium on his life and the new tasks of the mental-hygiene movement.

"The war and its aftermath present new and sharper challenges to mental hygiene. The war has proved anew the importance of mental soundness and health. It will leave on our doorsteps many new and unsolved problems of caring for and rehabilitating those who break under the stress of conflict and develop mental illness. Peace, too, will call for redoubled effort to prevent as well as cure and control mental illness and to make mental health more generally attainable.

"The medical profession and psychiatry, naturally, are alert to what lies ahead; the public sees the problem much less clearly. Yet mental health is an intimate concern of every home and individual in the land. Mental illness perhaps exacts a heavier toll

[1] For Dr. Winslow's address, see pages 179–85 of this issue of MENTAL HYGIENE.

of suffering, disappointment, frustration, and inefficiency than all other types of sickness combined.

"To-day, new frontiers of prevention and improved treatment call for exploration. For this, there must be both leaders and an informed public. Progress lights its lamps from the vision and venturing of its pioneers. Clifford Beers was one of the great pioneers for human health and happiness. This symposium on what he envisioned and accomplished will not only be a tribute to his achievements, but an inspiration to those carrying the torch with which he illumined the darkness of neglect and mistreatment of the insane. His crusading zeal was contagious. His flaming spirit, as well as cold science, are needed to-day. Our speakers have been chosen because of their peculiar qualifications to outline the immediate future of mental hygiene in the light of what has been achieved under the inspiring leadership of Mr. Beers and his associates."

Dr. Horatio M. Pollock Retires from State Service

After thirty-two years of distinguished and devoted service, Dr. Horatio M. Pollock, Director of the Bureau of Statistics of the New York State Department of Mental Hygiene, retired on December 31. To mark the event, the headquarters staff of the department gave a testimonial dinner in his honor at the DeWitt Clinton Hotel, Albany, on December 29. Commissioner Frederick MacCurdy presided and various speakers extolled Dr. Pollock's contributions and achievements. Tributes in the form of letters and telegrams were also presented from the directors of the twenty-six institutions of the department and from many organizations and individuals throughout the country.

To mention but a few of the achievements touched upon in the tributes to Dr. Pollock, he laid the basis for the system of statistical reports developed in the New York State service, which furnished the foundation for the nation-wide studies now carried on by the United States Bureau of the Census. "It was his masterful understanding and guidance that contributed most to its form and reliability," wrote Dr. William L. Russell. "His personal qualities of clear thinking, sound sense of values, sincere benevolence, and fearless loyalty to truth have given to his work a particular quality and value."

Recalling the epoch-making work of the American Psychiatric Association and The National Committee for Mental Hygiene a quarter of a century ago in formulating a standard nomenclature

of mental diseases and promoting the uniform system of statistical recording and reporting since adopted throughout the country, Dr. James V. May wrote that the tremendous work involved in this successful effort was "practically all" done by Dr. Pollock. And Dr. Samuel W. Hamilton called Dr. Pollock "the grandest statistician of them all," who "made figures illuminate our clinical problems . . . and spent several decades in patiently teaching us physicians that statistical reviews of our work are of prime importance."

These and other high lights of Dr. Pollock's varied and productive career were revealed by the speakers at the dinner, and at its close, Dr. MacCurdy, on behalf of the department staff, presented him with a handsome watch as a symbol of their affection and esteem.

Dr. Pollock made many contributions in the field of statistics, nationally and internationally as well as in New York State. He organized the system of records and statistics used by the Division of Neurology and Psychiatry of the Surgeon General's Office during World War I; he organized statistical systems in the state institutions of Illinois, in 1920, for the mentally ill, the defective, and the delinquent; he was for many years statistical consultant to The National Committee for Mental Hygiene and the Federal Census Bureau; and he headed the Committee on Statistics of the First International Congress on Mental Hygiene held in Washington in 1930.

In 1938, he prepared for the American Association for the Advancement of Science, in connection with the studies of its Division of Medical Sciences, a basic report to serve as a guide to state mental-health administrators in setting up statistical services. In addition, Dr. Pollock has done vitally important work in such fields as occupational therapy, family care for the mentally ill, the economics and sociology of mental diseases, and public education in mental hygiene. He has been not only the country's foremost mental-health statistician, but one of its outstanding mental hygienists. He has published many original studies which remain as guideposts to present and future progress in psychiatry and mental hygiene.

Progress Report on the Medical Survey Program

The following short statement on the progress of the Medical Survey Program recently launched to supply medical officers at induction stations with health, social, and educational histories

of registrants, has been submitted by Dr. Luther E. Woodward, Secretary of the Advisory Committee on Social Service, National Headquarters, Selective Service System. Dr. Woodward has been closely connected with the development of the program from the beginning. He reports:

"1. Noteworthy progress in the development of the medical survey is being made. In thirty-five states advisers to the state director have been appointed. Field agents in considerable numbers have been appointed in at least fifteen states, ranging in number from 58 in Montana to 1,200 in New York.

"A few states began to operate the medical survey late in December, several others in early January, still others by the middle of the month. Some states are still in the state of preliminary organization, but expect to have the survey functioning in the very near future.

"2. In New York City and in the state of Michigan, courses have been conducted for medical field agents and local-board personnel, especially the chief clerks. In New York City six lectures were presented by a psychiatrist, and there was group discussion both of the content of the lectures and of procedures to be used in the medical survey. In Michigan, attendance and participation by local board members and clerks was especially emphasized. In Alabama and South Carolina, sectional meetings in various parts of the state were held and attended by both medical field agents and local-board clerks. These meetings have resulted in marked stimulation of interest and clarification as to each person's function. It is very obvious that such courses and group meetings get greater results.

"3. The coöperation of secondary schools in most states has been outstanding, and in many states there is a constant stream of reports coming from the schools to state headquarters. A review of a sizable number of these reports indicates care in their compilation and in many instances the supplying of supplementary information.

"4. Several states are in process of establishing a central index of males of military age who have been institutionalized for insanity, epilepsy, feeblemindedness, or crime. Such an index greatly facilitates the clearance of registrants' names.

"5. The amount of space given in various social-work magazines and organization organs is greatly appreciated. At a recent meeting of the advisory committee, it was recommended that organizations be encouraged to continue to supply such material, as it is believed that there is a continuing need for additional information about the medical survey and for encouragement to the social-work groups to participate further. The writer contributed an article to the January number of the *Compass*. The advisory committee is ready to help editors in finding persons to write on the survey if help is needed.

"6. As to finances, almost continuous efforts have been made at national headquarters to obtain Federal funds with which to meet the costs of social-service-exchange clearances and reimbursements to state welfare departments for staff time used in the medical surveys in situations where the burden on such departments is heavy and costs cannot otherwise be met."

New Policies Governing Discharges from the Armed Forces

(From the *Journal of the American Medical Association*, January 15, 1944)

The war department in regulations dated December 15, 1943, has changed the regulations issued in November, 1942, regarding discharges from military service, particularly as they relate to tuberculosis, neuropsychiatric disorders, and malaria. The new regulations are as follows:

1. No individual with a disability incurred in line of duty will be discharged on certificate of disability until definite treatment has been completed, except those having tuberculosis or neuropsychiatric disorders. Types of cases which should be retained for treatment include those requiring skin graft, bone graft, revision of amputation stumps, closure of colostomy, etc.

2. Individuals unfit for army service because of neuropsychiatric disturbances will not be retained for definitive treatment, but will be discharged, and arrangements will be made for further care by the Veterans Administration if such is indicated. Exceptions are those individuals with neuropsychiatric conditions incurred incident to the service who, in the opinion of the medical officer, may within a reasonable period be returned to duty within the continental limits of the United States.

3. Enlisted personnel developing tuberculosis, unless terminal cases, will be transferred to Veterans Administration facilities and discharged as soon as a definite diagnosis of tuberculosis and disablement for further military service are determined. Exception to this policy may be made in the case of personnel nearing completion of twenty years' service and noncommissioned officers of the first three grades when the prognosis is favorable for a complete recovery and restoration to duty within one year. Such individuals will be transferred to Fitzsimons General Hospital, or other designated army hospital, for treatment.

4. Terminal cases and those in which such transfer will endanger the patient's life or recovery will be retained in the service and hospitalized until death ensues or transfer to a Veterans Administration facility becomes possible.

5. Individuals will not be separated from the military service solely because of malaria, in the absence of permanently incapacitating residuals or sequelæ such as marked splenomegaly or cachexia. Repeated relapses alone will not constitute a cause for separation.

6. When the enlisted man is to be separated from the service on

certificate of disability for discharge, irrespective of line of duty status, and further hospitalization is necessary, he will be transferred to a Veterans Administration facility and will be discharged.

Disposition of Neuropsychiatric Cases in the Armed Forces

The Office of the Surgeon General has issued a circular letter (No. 194) relative to the disposition of neuropsychiatric persons. It is realized that it is essential that all actual or potential neuropsychiatric cases be separated from the armed forces; but it is also felt that there are many cases who could be returned to combat duty. It has been proved that many soldiers who developed psychiatric disorders on combat duty were salvaged by skilled psychiatrists and returned to active duty.

An intensive study is made of each case to see whether the disorder arises from a temporary condition, or whether there is a fundamental cause that would necessitate the soldier's removal from the army. The cases are disposed of in one of the following ways:

1. Return to full duty. All those who after a careful study are found to be of potential value to the service are returned to active duty in the combat zones.

2. Return to less arduous duty. Those individuals who cannot stand the strain of full combat duty, but who could be of service in a less active field are, on recommendation of the medical officers, sent to duty either in continental United States or in a quiet sector overseas.

3. Separation from service. (a) Individuals who after careful study are believed to be of no further value to the service because of psychosis, neuropsychosis, epilepsy, or organic neurological disease will be separated from the service under the provisions of Section II AR, 615–300. (b) Individuals who after careful study are believed to be of no further value to the service because of the presence of mental deficiency, psychopathic personality, or primary behavior disorders (such as chronic alcoholism or drug addiction) will be discharged under the provisions of Section VIII AR 615–360.

Dr. Dean A. Clark to Head Physical Rehabilitation Section of Office of Vocational Rehabilitation

Federal Security Administrator Paul V. McNutt has announced the assignment of Dr. Dean A. Clark, surgeon, U. S. Public Health Service, as chief medical officer of the Office of Vocational Rehabilitation to take charge of the newly established Physical Rehabilitation Section. The arrangement between these two branches of the

Federal Security Agency was made by Surgeon General Thomas Parran at the request of Michael J. Shortley, director of vocational rehabilitation.

In commenting upon Dr. Clark's appointment, Mr. Shortley said that use of Federal funds for remedial medical treatment of the physically handicapped was authorized for the first time under the Barden-LaFollette Act of July 6, 1943.

"Until the expansion of the Vocational Rehabilitation Program under this new law," he said, "there was no Federal program for this purpose, although the Federal Government has long aided the states in providing vocational guidance and training for the handicapped. The addition of physical rehabilitation greatly strengthens the program, because relatively simple surgery often can materially decrease a physical handicap or even remove or fully compensate for it."

He explained that the new vocational-rehabilitation program will make an important contribution to the war effort by facilitating the employment of the physically handicapped and thus promoting effective use of man power for war work.

Mr. Shortley called attention to the fact that the rehabilitation program is designed to assist all physically handicapped individuals to obtain remunerative employment, except veterans with service-connected disabilities, who come under the program directed by the Veterans Administration. The program is operated by the states through their boards of vocational education and their official agencies for the blind.

As a war measure, the Federal Government pays the full cost of rehabilitating war-disabled civilians. These include officers and crew members incapacitated while on war duty in the merchant marine, and members of the Aircraft Warning Service, Civil Air Patrol, and U. S. Citizens Defense Corps. For other individuals, the Federal Government pays half the cost of rehabilitation. All administrative expenses of the states in conducting approved rehabilitation programs are also met with Federal funds. Under the new statute, Federal aid may be utilized to provide all types of medical and surgical service necessary to modify a physical condition which is static and which constitutes a substantial handicap to employment. Conditions for which medical services are undertaken must, however, be of such a nature that treatment may be expected to eliminate or substantially reduce them within a reasonable length of time. Hospitalization not to exceed ninety days may also be furnished, as well as prosthetic appliances essential for obtaining or retaining employment.

With Dr. Clark as chief medical officer, Mr. Shortley said, the

Physical Rehabilitation Program will be directed by a physician with both a broad training in several fields of medicine closely associated with rehabilitation work and also experience in public administration. Since 1938, Dr. Clark has been engaged in work connected with the organization and distribution of medical care. On the staff of the U. S. Public Health Service since 1939, he was assigned to the Division of Public Health Methods, National Institute of Health, until 1942; for the last year and a half he has served as chief of the Emergency Medical Section of the Public Health Service and as chief of the Hospital Section, Medical Division, Office of Civilian Defense. A native of Minnesota and a graduate of Princeton University, Dr. Clark's background includes three years as a Rhodes Scholar at Oxford University, England, where he received the degrees of bachelor of arts and bachelor of science in physiology. In 1932, he took his medical degree at the Johns Hopkins Medical School, Baltimore, Md. He served an internship in medicine at the Johns Hopkins Hospital; later he was assistant resident in medicine and neurology at the New York Hospital, New York, N. Y.; National Research Council fellow in neurophysiology at the Cornell University Medical College, New York City; assistant resident at the Henry Phipps Psychiatric Clinic, Johns Hopkins; and intern at Trudeau Sanatorium, Trudeau, N. Y.

Dr. Menninger Appointed Chief of Neuropsychiatric Branch in Surgeon General's Office

Lieutenant Colonel William C. Menninger, who has been neuropsychiatric consultant for the Fourth Service Command since he was called into service in November, 1942, has been appointed chief of the neuropsychiatric branch in the Office of the Surgeon General. He succeeds Colonel Roy D. Halloran, who died November 10, 1943. Dr. Menninger was graduated from Cornell University Medical School in 1924.

The chief objectives of the neuropsychiatric service are to screen out the unfit at the induction centers, to eliminate the mentally unstable from the service, to help maintain morale and discipline, and to treat and rehabilitate men who have incurred nervous and mental disorders arising out of military service.

More Beds for Neuropsychiatric Veterans

A supplemental appropriation of $30,000,000 for the Veterans Administration, for the fiscal year 1944, has been transmitted by the President to Congress. This sum, it is contemplated, will be used to provide 9,252 additional beds for neuropsychiatric patients.

The New Rochelle Child-Guidance Clinic

In February, 1942, a child-guidance clinic was opened in the city of New Rochelle, Westchester County, New York, to serve that city, the city of Mt. Vernon, and the towns of Larchmont, Mamaroneck, and Pelham. The clinic was organized as a demonstration clinic by a group of women interested in child welfare, with the hope that, the need for it once recognized, public agencies would take it over.

The center is a non-sectarian agency where therapy, not merely diagnosis, is the aim. It is open only one day a week. Cases are referred by the departments of family and of child welfare, the Visiting Nurse Association, the children's court, the department of public welfare, the department of health, private social agencies, schools, physicians, and parents. There is a sliding scale of fees, ranging from 25 cents to $3.00.

As a first step in the organization of the center, a survey was made by the community's public and private welfare agencies, schools, and children's courts, to see what guidance was already available. Fortunately the organizing group included women who had had professional experience in psychiatry and social welfare work.

Since the survey showed no mental-hygiene services available, an advisory and working committee was formed of women from the Parent-Teacher Association and the various women's clubs of the community. From this group officers and a board of governors were chosen, care being taken that all religious groups should be represented. A well-known pediatrician accepted the chairmanship of the organization; a bank president consented to act as treasurer; and school principals and the personnel director of a college joined the board of directors.

Conferences on clinic set-up and procedures were then held with Dr. Milton Kirkpatrick, of The National Committee for Mental Hygiene; Miss Katharine G. Ecob, of the New York State Committee on Mental Hygiene of the State Charities Aid Association; and Dr. Thomas P. Brennan, Director of the Psychiatric Institute of Grasslands Hospital, Westchester County. They all gave unstintingly of their time as consultants and advisers.

Plans were made for a part-time clinic, to be held one day at New Rochelle, as this city is centrally situated. The clinic was to be staffed by a paid psychiatric director, assisted by volunteer workers. Fortunately, well trained personnel were available, all of whom met with the approval of The National Committee for Mental Hygiene, which passed on their credentials.

To finance the clinic, bridge parties were held and memberships

and contributions were solicited. With $1,800 on hand, the Child Guidance Center was opened in February, 1942.

Three small rooms were acquired at a nominal rental and furniture was lent as a contribution by a former occupant of the place. In September, 1942, three large rooms on the same floor were added. These rooms have recently been newly decorated by the women of one of the clubs in New Rochelle.

In 1942 the staff had only one paid member—the psychiatric director; the other members—a psychologist, a registrar and intake worker, two secretaries, and several psychiatric social workers—were all volunteers. In 1944, in addition to the paid psychiatric director, the staff included a paid psychologist, four paid psychotherapists, and a paid psychiatric social worker. The three secretaries and two receptionists are still on a volunteer basis.

For the first year, the work was carried on with little publicity. A leaflet, *What is Child Guidance?* was mimeographed and distributed to interested groups and agencies. In 1943, with the clinic well established and the value of its services recognized by the community, an appeal was made for public funds in order that the scope of the work might be increased. In September, 1943, the clinic was voted $50.00 a month by the New Rochelle Board of Education and $100.00 by the New Rochelle Community Chest. In January, 1944, this latter sum was increased to $150.00. The Pelham Community Service, which receives its funds from the Community Chest, voted $300.00 for the clinic for 1944. Recently an application has been made to the city of New Rochelle for a sum of approximately $5,000, that the clinic may be open for another day, and appeals have been presented to the Community Chests of Larchmont and Mamaroneck.

From January 1 to December 31, 1942, the clinic's receipts were $2,188.11; its disbursements, $1,368.37. From January 1 to December 1, 1943, the receipts were $3,163.82, including the balance of $819.74 from 1942; the disbursements, $2,569.10.

In addition to its therapeutic work, the clinic carries on also an educational program. Several large meetings have been addressed by authorities in the psychiatric field, and the director and staff have, by invitation, addressed the New Rochelle Teachers Association, the Parent-Teacher Association, and various women's clubs. Also a course of lectures has been given by the staff to the Visiting Nurse Association.

Yale University Opens New Clinics

Yale University has announced the opening of two new diagnostic and guidance clinics for inebriates, one in New Haven, the other in Hartford. These clinics are the first of their kind in

America. The sponsors of this plan are the Connecticut Prison Association and the Yale Laboratory of Applied Physiology. Dr. Howard W. Haggard, Director of the Yale Laboratory, will have general oversight of the program. The chief medical director will be Dr. Ralph Banay, psychiatric consultant of the New York State Parole Board. He will direct both clinics. Dr. Anne Roe, research assistant in psychology at Yale, will be in charge of the psychological testing.

The staff of each clinic will be composed of psychiatrists, a psychologist, a social worker, and a clerk. Both clinics will be located in downtown districts. Cases may be referred by courts, welfare agencies, general hospitals, and private practitioners, or appointments may be made directly by patients or their relatives.

All patients will be interviewed by the psychiatrist and investigated by the social worker. The psychiatrist's recommendations will be based on his findings, modified by the patient's personality and the results of the social worker's investigations. Various recommendations will be given. Among them may be court or voluntary commitment for treatment, contact with Alcoholics Anonymous or the Salvation Army, and private treatment.

The plan calls for careful study and treatment of a small number of cases, to serve as a basis for future programs.

New Massachusetts Clinic A Memorial to Dr. Southard

The Massachusetts Department of Mental Health has recently opened a new clinic to be known as the Southard Clinic for Children and Adults. This clinic is a memorial to the late Dr. Elmer E. Southard, who in 1912 became the first director of the Boston Psychopathic Hospital.

Dr. Harry C. Solomon, professor of psychiatry at Harvard Medieal School, is the medical director. He will be assisted by two co-directors, Drs. Oscar J. Raeder and Edgar C. Yerbury. The staff will include five psychiatrists, one neurologist, six psychologists, and nine psychiatric social workers. The clinic will act as a mental-hygiene center for children and adults. It is an out-patient clinic equipped with all the modern facilities for studying and treating all types of neurological and psychiatric conditions. It will also serve as a teaching center for psychiatrists, physicians, nurses, and psychiatric social workers.

Annual Meeting of American Orthopsychiatric Association

The Twenty-first Annual Meeting of the American Orthopsychiatric Association was held at the Palmer House, Chicago, February 17–19, 1944, with Dr. George H. Preston presiding. The opening

session, on "The Origin of Group Prejudices," offered discussions on the dynamics of psychological and cultural factors in the formation of group prejudices from the viewpoint of anthropologist, psychiatrist, and psychologist. Round-table discussions were held on "Techniques for Investigating the Nature and Origin of Group Prejudices," "Levels and Applications of Group Therapy," "Human Relations and Morale in Industry," and "Rehabilitation." A variety of other papers were presented in the two and one-half-day sessions, under such topics as "Mental Health in the Military Services," "Clinical Studies," "Prophylaxis in War Time," "Preventive Aspects of Orthopsychiatry," and so on. The meeting was attended by 955 persons, representing thirty-five states and Canada. Newly elected officers of the association are Dr. Norvelle C. LaMar, President; Lawrence K. Frank, Vice-President; Nina Ridenour, Secretary; and Dr. James M. Cunningham, Treasurer.

One Hundred Years of American Psychiatry

On March 2, 1944, the Section of Historical and Cultural Medicine of the New York Academy of Medicine and the New York Society for Medical History celebrated the Centennial of American Psychiatry. The speakers were Dr. Edward A. Strecker, Philadelphia, Dr. Adolf Meyer, Baltimore, and Dr. John Whitehorn, Baltimore. The papers were discussed by Dr. Arthur H. Ruggles, of Providence, and Drs. A. A. Brill and Gregory Zilboorg of New York City.

Advanced Postgraduate Programs in Psychiatric Nursing

Thoughtful administrators of nursing-school educational programs are giving serious consideration to the need for the inclusion of psychiatric nursing as part of the preparation of every student nurse and as one of the "specialty" experiences for the senior student cadet nurse. But the question is frequently asked: "Where and how is this experience to be obtained?"

Clinical facilities are plentiful. Even before the outbreak of this war, the number of patients in psychiatric institutions was greater than the number of patients in all the institutions for other types of illness. As time goes on, the stress of the war will undoubtedly increase the proportion of patients in psychiatric institutions. The means by which this clinical material can be made meaningful to student nurses depends on qualified teaching personnel, which at present is not available to meet existing needs.

Two universities have recently set up educational programs to prepare qualified graduate nurses for psychiatric-nursing positions as

head nurses, instructors, and supervisors. The school of Nursing Education, Catholic University of America, Washington, D. C. and the School of Nursing Education, University of Minnesota, Minneapolis, Minnesota, are prepared to offer courses basic to the understanding and interpretation of human behavior. Carefully selected and guided experiences in psychiatric institutions follow through the application of the theory course in the principles of teaching and supervision in psychiatric nursing.

Federal scholarships are available for those graduate nurses who have shown aptitude for leadership in psychiatric education. If such individuals could be encouraged to take advantage of the opportunities offered by these two schools, a nucleus could be formed through which eventually many areas could be reached.

Dr. Harvey Spencer Joins Staff of Austin Riggs Foundation

Dr. Charles H. Kimberley, Medical Director of the Austin Riggs Foundation, has announced that Dr. Harvey Spencer has resigned as acting director of the Habit Clinic for Child Guidance and as psychiatrist at the Judge Baker Guidance Center, Boston, to join the staff of the Austin Riggs Foundation, Stockbridge, Massachusetts.

Dr. Philip Smith

Dr. Philip Smith, chief medical examiner of the New York State Department of Mental Hygiene (New York office), died of pneumonia and heart complications at the Brooklyn State Hospital, on January 8.

Dr. Smith was born seventy-one years ago near Scranton, Pennsylvania. He studied medicine at Physicians and Surgeons, Columbia University. After entering state service in 1900, he was for several years stationed at Manhattan State Hospital, Ward's Island. He held several positions with the New York State Department of Mental Hygiene prior to his appointment seventeen years ago as chief medical examiner.

Dr. Smith was well known in medical circles throughout the state. He was a member of the American Psychiatric Association and other medical organizations. In World War I, he served overseas as a major in the Army Medical Corps.

Stern Book Wins Praise in England

A note highly commending Mrs. Edith Stern's book, *Mental Illness: A Guide for the Family,* appears in the London *Lancet* for December 4, 1943. The book, which was published by the Commonwealth Fund, of New York, in 1942, was written in collabo-

ration with Dr. Samuel W. Hamilton, Mental Hospital Adviser of the Division of Mental Hygiene, U. S. Public Health Service, and Director of the Division on Hospital Service of The National Committee for Mental Hygiene. The note is as follows:

> "Every psychiatrist and indeed every doctor has to explain to relatives what mental illness and admission to a mental hospital really entails. It is a difficult task, but the rewards for executing it well are great. Often, however, those to whom the explanation and reassurance are addressed are too deeply stirred, or too much influenced by common prejudices about insanity, to be able to grasp what has been told them; often, too, the doctor lacks the time, and perhaps the skill, to allay all their fears and doubts. Mrs. Stern's book will, to a great extent, fulfil the task for him. It is so arranged that the successive stages and problems which will confront relatives are dealt with seriatim. The first few chapters cover the attitude towards mental illness, the need for hospital treatment, desirability of a public or a private hospital for the patient, procedure of admission, getting the patient to the hospital, and the first few weeks there. The latter part of the book describes life in the mental hospital and gives advice about letters, visiting, parole, attitude after discharge from hospital and finally about the responsibility of all citizens for the mental health services in their community. Medical details are eschewed; there are no descriptions of symptoms, helps to diagnosis, or names of diseases. Here and there differences of an unessential kind between American procedures and ours will occur to the English reader, but they do not reduce the great usefulness which such a manual could have in modifying the attitude of the public in this country and lessening the avoidable misery incident to mental illness. Sensible, clear, unsentimental, and humane, the book is a model instrument of public health education. It would be a very suitable use of the funds and influence of the National Council for Mental Hygiene if it could subsidize or otherwise promote the publication of the book here, where it is at present virtually unprocurable."

Magazine Publication for Ribble Book

The Columbia University Press, publishers of Dr. Margaret Ribble's *The Rights of Infants*, has granted permission to the *Ladies Home Journal* to publish a condensed version of the book, which is receiving very favorable attention. The demand for it has been so great that the first printing is already exhausted and a second is under way.

The book is in part the outcome of a study carried on under a grant from funds donated by Supreme Council, 33°, Northern Masonic Jurisdiction, Scottish Rite, U. S. A., to The National Committee for Mental Hygiene, to be used in financing research projects. Dr. Nolan D. C. Lewis, Director of the New York State Psychiatric Institute and Hospital, is in charge of the selection of projects and the allocation of funds. In the preface to her book, Dr. Ribble has acknowledged her indebtedness to the Scottish

Rite Masons and to Dr. Lewis, and as a further expression of appreciation, has dedicated the book to Melvin Maynard Johnson, Grand Commander, Supreme Council, 33°.

State Society News

Iowa

Dr. Norman D. Render, Superintendent of the Clarinda State Hospital, Iowa, has sent the following letter to doctors, teachers, and prominent laymen throughout the state:

> "Thinking of the inevitable post-war problems, in addition to the already heavily increased civilian load, a number of interested people are considering the formation of a state-wide mental-hygiene committee, and wonder if you would be interested in membership. The purposes of the organization will be (1) public education in mental health, (2) understanding of Iowa's program for child and family welfare and state institutions, and (3) tie-up with The National Committee for Mental Hygiene, already represented in twenty-six states.
>
> "To form such a society, we need wide representation in professional, lay, and religious groups. So far we have had expressions of interest from seventy-five people and hope to double this number by the spring meeting.
>
> "I take pleasure in inviting you to join this project, and to suggest to us other prominent and socially minded people who may be interested. We expect to hold our first annual meeting in April, and hope you can attend to help adopt a constitution and elect officers."

Kentucky

The Executive Board of the Kentucky Mental Hygiene Association met in Lexington, Kentucky, on February 28, and reëlected its officers. A special tribute of appreciation was expressed to Reverend J. O'Bryan, who has served the association since the beginning as its president, and who had announced his resignation. He, however, was unanimously reëlected to the presidency and accepted when prevailed upon by the board to carry on for at least another year.

Dr. A. M. Lyon, Director of the Division of Hospitals and Mental Hygiene, Department of Welfare, Commonwealth of Kentucky, has been chosen by the University of Kentucky to head a course of lectures on mental hygiene to the graduate students in 1943–44. The series of lectures given by Dr. Lyon will continue throughout the coming semester. This is the first time the director of the division has been asked to serve in such a capacity at the university, and reports come from many sources to the effect that there is great interest in the series of lectures.

The new Governor of Kentucky, Simeon D. Willis, has appointed

Joshua Everett as welfare commissioner, to succeed W. A. Frost, who had served as commissioner for three years. Since the Division of Hospitals and Mental Hygiene is one of the six divisions of the state welfare department, the appointment of a new commissioner is an important event to the Kentucky Mental Hygiene Association.

The Kentucky Mental Hygiene Association is encouraging the formation of county units, and the Fayette County unit, with headquarters at Lexington, is a very active part of the state association. As a phase of the interpretation program, the board of that unit has been broadcasting a series of round tables on mental hygiene, on Sundays, at noon. This program has become quite popular.

Minnesota

Minnesota is becoming very much aware of the problem of discharged servicemen, and the mental-hygiene society is gearing itself to stimulate the establishment of information and reference centers and to act in an advisory capacity, particularly in regard to psychiatric reference and treatment.

On January 19, the society was joint sponsor, with the Twin City Chapter of the American Association of Social Workers, of an open meeting at which Dr. Alexander Dumas, of the Veterans Administration of Minneapolis, spoke on "The Psychologic and Emotional Factors Encountered in Returning Servicemen and the Resources Available for Meeting Them: Medical Care, Hospitalization, Rehabilitation, and Reorientation to Employment." At the convention of the National Association of Manufacturers held in New York in December, Dr. Dumas had taken part in a panel discussion of this subject, and he included in his lecture some of the impressions he had gathered there. Shortly after this meeting, the society laid the groundwork for the establishment of rehabilitation committees which would work with the Red Cross in Ramsey and Hennepin Counties, and the Ramsey County Committee has already secured psychiatric treatment for a number of cases.

To fill vacancies on the board, the society has elected two men who are especially qualified to function on this problem—Dr. Dumas, and Dr. A. F. Pringle, of the Veterans Administration in St. Cloud.

A subcommittee of the executive committee has drawn up an organizational plan for a center in Minneapolis, and is now clearing with a subcommittee from the Council of Social Agencies. The society is prepared to coöperate and clear with the state of Minnesota on the establishment of centers in the larger metropolitan areas of the state, and expects to invite Dr. Luther E. Woodward to come to Minnesota for conferences on the problem.

The clinical section of the society, composed of social workers and teachers in the Twin Cities, has added many new members to itself and the society this year, particularly at its last meeting on February 28, when a panel discussion was held on "The Commitment of Children." The speakers were Miss Opal Jacobs, head of the Bureau of Child Placement of the Division of Social Welfare; Miss Kathryn Mullinix, Children's Protective Society of Minneapolis; Dr. E. J. Engberg, Superintendent of the State School for the Feebleminded at Faribault; and Miss Rose Greene, School of Social Work, University of Minnesota.

The annual meeting of the society will be held during the State Conference of Social Work early in May, at which time there will be an election of eight members to the board of directors. The speaker has not yet been selected, but the subject will undoubtedly be some phase of the problem of neuropsychiatric casualties and the resources in Minnesota for caring for them.

New Publications

The National Committee for Mental Hygiene now has available a selected list of recently published books on mental hygiene and related subjects. Copies are obtainable on request.

Recent additions to the National Committee's pamphlet literature are: *The Ministry of Counseling,* by Rollo May (10¢); *The Ministry of Listening,* by Russell L. Dicks (10¢); and *When Children Ask About Sex* (20¢).

Librarians, counselors, deans, teachers, school administrators, employment interviewers, and vocational rehabilitation officers will be interested in "Best Books of 1943 on Occupational Information and Guidance," a new selection by Robert Hoppock, Kathleen Pendergast, Elizabeth Rosso, and Samuel Spiegler, just released by Occupational Index, Inc. at New York University, New York 3, N. Y. Single copies are 25¢, cash with order.

The forty-one titles are arranged in suggested order of purchase with twenty free or inexpensive pamphlets listed first.

Returning soldiers, ex-war workers, students, teachers, parents, counselors, and others who want to know about professional opportunities in helping injured persons to reëstablish themselves economically, will want to read the composite summary of available literature on "Vocational Rehabilitation as a Career" just completed by Sarah Allen Beard and published by Occupational Index, Inc., New York University, New York 3, N. Y. Single copies are 25¢, cash with order.

This is the fourth in a new series of occupational abstracts, covering occupations in which post-war employment prospects are good. The editor of the series is Professor Robert Hoppock, of New York University. Advance orders for the next ten in the series may be placed now at $2.50.

Twenty-Eighth Printing of "A Mind That Found Itself"

Because of the continued demands for Clifford Beers's autobiography, *A Mind That Found Itself*, it has been necessary to undertake a twenty-eighth printing of the book. We make this announcement so that the many readers who have requested copies and been unable to obtain them because the stock was exhausted may know that the book will be off the press by the 15th of April.

Back Issues of "Mental Hygiene" Wanted

The following issues of Mental Hygiene are out of print: January, 1937; October, 1938; January, 1939; January, 1940; January and April, 1941; October, 1942; and April, 1943. The National Committee for Mental Hygiene would be very grateful for any copies of these issues that subscribers may not care to keep.

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